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INSTRUCTIONS

TO **ENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO **FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00193

213 CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>COCKEYSVILLE</u>		LENGTH OF STAY (If this place) <u>11 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>JOPPA</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MASONIC HOME</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>ERNEST ACKERMAN</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JAN 14 19 57</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>4-3-1870</u>	9. AGE last birthday <u>86</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HARNESS MAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>ANDREW ACKERMAN</u>				14. MOTHER'S MAIDEN NAME <u>ADELAIDE MORGENRODE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>Frank Smith Jr. ind. Cockeysville, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Arterio Sclerotic Cardiac</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO <u>Vascular disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/9/57</u> , 19 <u>57</u> , to <u>1/14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/14</u> , 19 <u>57</u> , and that death occurred at <u>3:25 P.M.</u> , from the causes and on the date stated above. SIGNATURE <u>Walter T. Hees</u> M. D. <u>Cockeysville Md.</u> DATE SIGNED <u>1/14/57</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>1-12-57</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel</u>		LOCATION (City, town, or county) (State) <u>BALTO MD</u>	
24. REC'D BY REGISTRAR DATE <u>1/15/57</u>		REGISTRAR'S SIGNATURE <u>Frank Smith Jr.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook</u>		ADDRESS <u>1217 St Paul St.</u>	

BUREAU V. S.

JAN 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00194

33

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cherry Hill Lane		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown	
f. STREET ADDRESS Cherry Hill Lane		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Donna Middle Larue Last Allewalt		4. DATE OF DEATH Month Jan. Day 23 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 25, 1952
9. AGE (In years last birthday) 4 yrs.		IF UNDER 1 YEAR Months 4 Days 19	IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md.	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Donald Allewalt		14. MOTHER'S MAIDEN NAME LaRue Rutledge	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Donald Allewalt, Reisterstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Compound Communicated Fractured Skull 812X DUE TO (run over by oil truck) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 812X DUE TO (run over by oil truck) (c)			
INTERVAL BETWEEN ONSET AND DEATH 15 min.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Run over by oil truck	
20c. TIME OF INJURY Month, Day, Year Hour XX p. m. Jan. 23, 1956		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Driveway		20f. (City or town) (County) (State) Reisterstown, Balto., Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE D. D. Caples		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) D. D. Caples, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 1-25-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 26, 1957	
22c. NAME OF CEMETERY OR CREMATORY Western		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Witzke, Baltimore 29, Md.		24a. REC'D BY REGISTRAR 1-25-57	
24b. REGISTRAR'S SIGNATURE Mary B. Elise			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John H. H. Jones	
Residence		Cherry Hill Lane	
Age		38 years	
Sex		Male	
Race		White	
Date of Death		Jan. 28, 1957	
Place of Death		Home	
Cause of Death		Coronary Arteriosclerosis	
Manner of Death		Natural	
Signature of Medical Examiner		[Signature]	
Signature of Coroner		[Signature]	

BUREAU V. S.
JAN 28 1957
RECEIVED

RECEIVED
JAN 28 1957
BALTIMORE

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

00195

41

Reg. Dist. No.

193

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		LENGTH OF STAY (in this place) <u>8 YRS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		OR TOWN <u>22</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>94 KENTWAY</u>				STREET ADDRESS (If rural give location) <u>94 KENTWAY</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>FRANK</u> (Middle) <u>PETER</u> (Last) <u>AMANN</u>				(Month) <u>1-18-</u> (Day) <u>19</u> (Year) <u>57</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>SEPT 18, 1879</u>	9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FOREMAN</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL INDSTR.</u>		11. BIRTHPLACE (State or foreign country) <u>KENNA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>WM. AMANN</u>				14. MOTHER'S MAIDEN NAME <u>MARY FLECKENSTEIN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>24-07-1327</u>		17. INFORMANT & ADDRESS <u>ELENE WHALEN - SAME</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.2 IMMEDIATE CAUSE (A) <u>CHRONIC MYOCARDITIS</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 YRS.</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 18, 1953</u> , to <u>Jan 21, 1957</u> , that I last saw the deceased alive on <u>Jan 18, 1957</u> , and that death occurred at <u>3:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>W. B. Davis</u>				DATE SIGNED <u>M.D. 6800 Mornington Ln Dundalk, Md 1/21/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>1-21-57</u>		NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER</u>		LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Wm. Kelly</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Luke Bradley, Dundalk, Md.</u>		ADDRESS	
DATE <u>JAN 21 1957</u>							

VS A1S (4)
1SM 9/SS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JAN 12 1907	
AGE		SEX	
35		Male	
RACE		COLOR	
White		White	
BIRTH DATE		BIRTH PLACE	
JAN 15 1872		BALTIMORE, MD.	
MARRIAGE DATE		MARRIAGE PLACE	
JAN 15 1890		BALTIMORE, MD.	
OCCUPATION		CAUSE OF DEATH	
None		Heart Disease	
PLACE OF DEATH		MANNER OF DEATH	
Home		Natural	
DATE OF INTERMENT		PLACE OF INTERMENT	
JAN 15 1907		CATHOLIC CHURCH	

NAME OF FUNERAL HOME		NAME OF FUNERAL HOME	
JAMES H. HARRIS		JAMES H. HARRIS	
ADDRESS		ADDRESS	
1234 N. E. ST.		1234 N. E. ST.	
CITY		CITY	
BALTIMORE		BALTIMORE	
STATE		STATE	
MD.		MD.	
DATE OF DEATH		DATE OF DEATH	
JAN 12 1907		JAN 12 1907	
PLACE OF DEATH		PLACE OF DEATH	
Home		Home	
MANNER OF DEATH		MANNER OF DEATH	
Natural		Natural	
OCCUPATION		OCCUPATION	
None		None	
CAUSE OF DEATH		CAUSE OF DEATH	
Heart Disease		Heart Disease	
MANNER OF DEATH		MANNER OF DEATH	
Natural		Natural	
OCCUPATION		OCCUPATION	
None		None	
CAUSE OF DEATH		CAUSE OF DEATH	
Heart Disease		Heart Disease	

RECEIVED
JAN 15 1907
BUREAU V. S.
JAN 15 1907
JAN 15 1907

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Notch Cliff Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Notch Cliff near Towson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenarm Road		d. STREET ADDRESS 1 Glenarm Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Sister Mary Liboria Arndt		4. DATE OF DEATH Month Day Year January 30 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 23, 1873
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Allentown, Pa.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Arndt		14. MOTHER'S MAIDEN NAME Anna Kieser	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Sister M. Peter Fourier		Address Notch Cliff Md.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of intestines 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from May 29, 1952 , to Jan. 22, 1957 , that I last saw the deceased alive on Jan. 22, 1957 , and that death occurred at 2:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Charles F. O'Donnell M.D. 7501 York Road Towson 4, Md.		
ACTUAL SIGNATURE Charles F. O'Donnell		
PHYSICIAN'S NAME (Type) Charles F. O'Donnell M.D.		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF FEB. 1, 1957	22c. NAME OF CEMETERY OR CREMATORY VILLA MARIA CEM
22d. LOCATION (City, town, or county) (State) NOTCH CLIFF NR TOWSON, MD		
23. FUNERAL DIRECTOR'S SIGNATURE Charles F. O'Donnell		24a. REC'D BY REGISTRAR 1-30-57
ADDRESS 901 S. CONKLING ST. BALTO., MD.		24b. REGISTRAR'S SIGNATURE Matel Guy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00198

217

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>COCKEYSVILLE</u> LENGTH OF STAY (in this place) <u>3 YEARS</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY _____ CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTIMORE 3 Vol-4</u> STREET ADDRESS (If rural give location) <u>3907 DORCHESTER RD</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>CARRIE JANE BANGS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JAN 26 19 57</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>AUG-4-1870</u>	9. AGE last birthday <u>86</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S</u>	
13. FATHER'S NAME <u>JESSE ARNOLD</u>				14. MOTHER'S MAIDEN NAME <u>MARY E.J. GOLLEY.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S ADDRESS <u>Frank L. Smith Jr Cockeysville, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 422.1 IMMEDIATE CAUSE (A) <u>Arterio-Sclerotic Cardio</u> ANTECEDENT CAUSE(S) DUE TO <u>Vascular disease</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) _____ (C) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 year.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED				21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1-16</u> , 19 <u>53</u> , to <u>1-25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-25</u> , 19 <u>57</u> , and that death occurred at <u>5:22 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Walter T. Lees</u>		M.D. <u>Cockeysville, Md.</u>		DATE SIGNED <u>1/26/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-30-57</u>		NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		LOCATION (City, town, or county) (State) <u>BALTO. Md</u>	
24. REC'D BY REGISTRAR <u>JAN 29 1957</u>		REGISTRAR'S SIGNATURE <u>Frank Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>WILLIAM COOK/KC 1517 ST PAUL ST</u>			

CERTIFICATE OF DEATH

FILE NO.

1. PLACE OF DEATH

2. SEX

3. AGE

4. DATE

5. TIME

6. PLACE

7. CAUSE

8. MANNER

9. OCCASION

10. SIGNATURE

11. DATE

12. TIME

13. PLACE

14. CAUSE

15. MANNER

16. OCCASION

17. SIGNATURE

18. DATE

19. TIME

20. PLACE

21. CAUSE

22. MANNER

23. OCCASION

24. SIGNATURE

25. DATE

26. TIME

27. PLACE

28. CAUSE

29. MANNER

30. OCCASION

31. SIGNATURE

32. DATE

33. TIME

34. PLACE

35. CAUSE

36. MANNER

37. OCCASION

38. SIGNATURE

39. DATE

40. TIME

41. PLACE

42. CAUSE

43. MANNER

44. OCCASION

45. SIGNATURE

46. DATE

47. TIME

48. PLACE

49. CAUSE

50. MANNER

51. OCCASION

52. SIGNATURE

53. DATE

54. TIME

55. PLACE

56. CAUSE

57. MANNER

58. OCCASION

59. SIGNATURE

60. DATE

61. TIME

62. PLACE

63. CAUSE

64. MANNER

65. OCCASION

66. SIGNATURE

67. DATE

68. TIME

69. PLACE

70. CAUSE

71. MANNER

72. OCCASION

73. SIGNATURE

74. DATE

75. TIME

76. PLACE

77. CAUSE

78. MANNER

79. OCCASION

80. SIGNATURE

81. DATE

82. TIME

83. PLACE

84. CAUSE

85. MANNER

86. OCCASION

87. SIGNATURE

88. DATE

89. TIME

90. PLACE

91. CAUSE

92. MANNER

93. OCCASION

94. SIGNATURE

95. DATE

96. TIME

97. PLACE

98. CAUSE

99. MANNER

100. OCCASION

101. SIGNATURE

102. DATE

103. TIME

104. PLACE

105. CAUSE

106. MANNER

107. OCCASION

108. SIGNATURE

109. DATE

110. TIME

111. PLACE

112. CAUSE

113. MANNER

114. OCCASION

115. SIGNATURE

116. DATE

117. TIME

118. PLACE

119. CAUSE

120. MANNER

121. OCCASION

122. SIGNATURE

123. DATE

124. TIME

125. PLACE

126. CAUSE

127. MANNER

128. OCCASION

129. SIGNATURE

130. DATE

131. TIME

132. PLACE

133. CAUSE

134. MANNER

135. OCCASION

136. SIGNATURE

137. DATE

138. TIME

139. PLACE

140. CAUSE

141. MANNER

142. OCCASION

143. SIGNATURE

144. DATE

145. TIME

146. PLACE

147. CAUSE

148. MANNER

149. OCCASION

150. SIGNATURE

151. DATE

152. TIME

153. PLACE

154. CAUSE

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156. OCCASION

157. SIGNATURE

158. DATE

159. TIME

160. PLACE

161. CAUSE

162. MANNER

163. OCCASION

164. SIGNATURE

165. DATE

166. TIME

167. PLACE

168. CAUSE

169. MANNER

170. OCCASION

171. SIGNATURE

172. DATE

173. TIME

174. PLACE

175. CAUSE

176. MANNER

177. OCCASION

178. SIGNATURE

179. DATE

180. TIME

181. PLACE

182. CAUSE

183. MANNER

184. OCCASION

185. SIGNATURE

186. DATE

187. TIME

188. PLACE

189. CAUSE

190. MANNER

191. OCCASION

192. SIGNATURE

193. DATE

194. TIME

195. PLACE

196. CAUSE

197. MANNER

198. OCCASION

199. SIGNATURE

200. DATE

201. TIME

202. PLACE

203. CAUSE

204. MANNER

205. OCCASION

206. SIGNATURE

207. DATE

208. TIME

209. PLACE

210. CAUSE

211. MANNER

212. OCCASION

213. SIGNATURE

214. DATE

215. TIME

216. PLACE

217. CAUSE

218. MANNER

219. OCCASION

220. SIGNATURE

221. DATE

222. TIME

223. PLACE

224. CAUSE

225. MANNER

226. OCCASION

227. SIGNATURE

228. DATE

229. TIME

230. PLACE

231. CAUSE

232. MANNER

233. OCCASION

234. SIGNATURE

235. DATE

236. TIME

237. PLACE

238. CAUSE

239. MANNER

240. OCCASION

241. SIGNATURE

242. DATE

243. TIME

244. PLACE

245. CAUSE

246. MANNER

247. OCCASION

248. SIGNATURE

249. DATE

250. TIME

251. PLACE

252. CAUSE

253. MANNER

254. OCCASION

255. SIGNATURE

256. DATE

257. TIME

258. PLACE

259. CAUSE

260. MANNER

261. OCCASION

262. SIGNATURE

263. DATE

264. TIME

265. PLACE

266. CAUSE

267. MANNER

268. OCCASION

269. SIGNATURE

270. DATE

271. TIME

272. PLACE

273. CAUSE

274. MANNER

275. OCCASION

276. SIGNATURE

277. DATE

278

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00199

218

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville - 28		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor Nursing		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Baltimore County	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 5708 Hamilton Avenue	
3. NAME OF DECEASED (Type or print) First Catherine Middle J. Last Basel		4. DATE OF DEATH Month January Day 8 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 20, 1889
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George Telljohann		14. MOTHER'S MAIDEN NAME Catherine Mayer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-05-9152	
17. INFORMANT Charles A. Basel		Address 5708 Hamilton Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 481X Myocarditis, viral DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Influenza, acute DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 days 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Hemorrhage		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-29, 1957 , to 1-8, 1957 , that I last saw the deceased alive on 1-8, 1957 , and that death occurred at 10:02 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE John F. Schaefer M.D.		ADDRESS (Street, city or town, state) 401 Ransom Road Baltimore, Md.	
PHYSICIAN'S NAME (Type) JOHN F. SCHAEFER		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 11, 1957	
22c. NAME OF CEMETERY OR CREMATORY Sacred Heart		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc.,		ADDRESS 403 S. Wolfe Street	
24a. REC'D BY REGISTRAR 1/10/57		24b. REGISTRAR'S SIGNATURE H. H. Hedrick	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00200

219

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baldwin</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baldwin</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Baldwin, Md.</u>		d. STREET ADDRESS <u>Baldwin, Md.</u>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Mary</u> Last <u>Bennett</u>		4. DATE OF DEATH Month <u>January</u> Day <u>4</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 8, 1879</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Carroll, Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George A. Fleming</u>		14. MOTHER'S MAIDEN NAME <u>Virginia H. R. Davis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>	
17. INFORMANT <u>Mr. Thomas F. Bennett</u>		Address <u>Baldwin, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of stomach</u> 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>14 Mths</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 4, 1928</u> to <u>Jan 4, 1927</u> , that I last saw the deceased alive on <u>Jan 4, 1927</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walter M. Hammett</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Walter Hammett</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 7, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fork Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Fork, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louise Funeral Home</u>		ADDRESS <u>7401 Belair Rd.</u>	
24a. REC'D BY REGISTRAR <u>1-5-57</u>		24b. REGISTRAR'S SIGNATURE <u>W M Hammett</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
DATE OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]		CITY OF DEATH [REDACTED]	
TIME OF DEATH [REDACTED]		CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]	
PLACE OF BIRTH [REDACTED]		DATE OF BIRTH [REDACTED]		SEX OF BIRTH [REDACTED]	
OCCUPATION [REDACTED]		EDUCATION [REDACTED]		RELIGION [REDACTED]	
MARITAL STATUS [REDACTED]		PREVIOUS MARRIAGES [REDACTED]		PREVIOUS DEATHS [REDACTED]	
SIGNATURE OF DECEASED [REDACTED]		SIGNATURE OF WITNESS [REDACTED]		SIGNATURE OF PHYSICIAN [REDACTED]	
SIGNATURE OF CORONER [REDACTED]		SIGNATURE OF JURY [REDACTED]		SIGNATURE OF JUDGE [REDACTED]	
SIGNATURE OF CLERK [REDACTED]		SIGNATURE OF REGISTRAR [REDACTED]		SIGNATURE OF ARCHIVIST [REDACTED]	

BUREAU V. 3

JAN 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00201

220

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville Rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cuba Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Thomas Benson Jr.		4. DATE OF DEATH Jan. 7, 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 24, 1900
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Government Employee		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William T. Benson Sr.		14. MOTHER'S MAIDEN NAME Louise Lawrence	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Marcella F. Benson - same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic C.V. Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 min. 4 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 1956, to January , 1957, that I last saw the deceased alive on December 28 , 1956, and that death occurred at 9:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Martin E. Strobel		ADDRESS (Street, city or town, state) 48 Main St. Reisterstown DATE SIGNED 1/8/57	
PHYSICIAN'S NAME (Type) Martin E. Strobel		48 Main St. Reisterstown, Md. 1/8/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 10, 1957	22c. NAME OF CEMETERY OR CREMATORY Balto. National	22d. LOCATION (City, town, or county) (State) Balto. City Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lenord J. Ruck		ADDRESS 5305 Harford Rd.	
24a. REC'D BY REGISTRAR DATE 10 1957		24b. REGISTRAR'S SIGNATURE H. H. Hedrich	

continued

• *Adipose tissue*

Foreign Service Institute

• 2000 •

JAN 10 1957

RECEIVED

0416E

ENCLOSURE NO. 8 OF 10

1991

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00202

221

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 11mths14dys		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL			e. STREET ADDRESS 5310 Norwood Avenue		
3. NAME OF DECEASED (Type or print) Anna			4. DATE OF DEATH January 28 1957		
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Aug. 26, 1887		9. AGE (In years last birthday) yrs. 69		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) garment maker		10b. KIND OF BUSINESS OR INDUSTRY garment		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 0 214-30-2664		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
INTERVAL BETWEEN ONSET AND DEATH					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from Dec. 14 , 19 56 , to Jan. 28 , 19 57 , that I last saw the deceased alive on Jan. 28 , 19 57 , and that death occurred at 8:30a. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Stella Wachslar M.D. SPRING GROVE STATE HOSPITAL 1-28-57 PHYSICIAN'S NAME (Type) Stella Wachslar, M. D. Catonsville 28, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 1/29/57		22c. NAME OF CEMETERY OR CREMATORY Cathedral	
22d. LOCATION (City, town, or county) (State) West Frederick Rd		24a. REC'D BY REGISTRAR DATE JAN 30 57		24b. REGISTRAR'S SIGNATURE Outenrich	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Fisher, 1318 Light					

CERTIFICATE OF DEATH

201

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

10025

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>	
<p>3. AGE [REDACTED]</p>		<p>4. DATE OF BIRTH [REDACTED]</p>	
<p>5. PLACE OF BIRTH [REDACTED]</p>		<p>6. OCCUPATION [REDACTED]</p>	
<p>7. MARITAL STATUS [REDACTED]</p>		<p>8. CAUSE OF DEATH [REDACTED]</p>	
<p>9. MANNER OF DEATH [REDACTED]</p>		<p>10. PLACE OF DEATH [REDACTED]</p>	
<p>11. DATE OF DEATH [REDACTED]</p>		<p>12. TIME OF DEATH [REDACTED]</p>	
<p>13. SIGNATURE OF DECEASED [REDACTED]</p>		<p>14. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>15. SIGNATURE OF PHYSICIAN [REDACTED]</p>		<p>16. SIGNATURE OF CORONER [REDACTED]</p>	
<p>17. SIGNATURE OF REGISTRAR [REDACTED]</p>		<p>18. SIGNATURE OF CLERK [REDACTED]</p>	

BUREAU V. 8

JAN 30 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The coroner's copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00203

CERTIFICATE OF DEATH

222

Item 7, Film G210, 2/4/57 bh

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>Balt</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
TOWN <u>CATONSVILLE</u>		<u>9 MONTHS</u>		TOWN <u>BALTIMORE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PARADISE NURSING HOME</u>				STREET ADDRESS (If rural give location) <u>736 Frederick Ave (28)</u>			
3. NAME OF DECEASED (Type or Print) <u>MARGARET L. BILLINGS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JAN. 29, 1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>NOV. 30, 1914</u>	
9. AGE last birthday <u>42</u> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>WALTER GRADY</u>				14. MOTHER'S MAIDEN NAME <u>Louise M. MILLER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>736 Frederick Ave Mrs. Louise M. MILLER (28)</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
170X IMMEDIATE CAUSE (A) <u>Carcinomatosis, lungs, bones, brain</u>						1 year?	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma, left breast axillary metas</u>						3 yrs 6 mos	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>11-20-53</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma breast-axillary metastases</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. A. P. M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-20</u> , 19 <u>56</u> , to <u>1-29</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-19</u> , 19 <u>57</u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Stephen L. Leach</u>				ADDRESS (Street, city, town, state) <u>908 Frederick Rd Catonsville, Md</u>		DATE SIGNED <u>1-29-57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Feb. 1, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>LODGE PARK</u>		LOCATION (City, town, or county) (State) <u>BALTO. Md.</u>	
24. REC'D BY REGISTRAR <u>Al Leach</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ed Truman Schvach</u>		ADDRESS <u>3512 Frederick Ave. (29)</u>	
DATE <u>JAN 31 '57</u>							

00808

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

CERTIFICATE OF DEATH

Year Day

at the residence of the deceased

PLACE OF DEATH

NAME OF DECEASED
AGE
SEX
RACE
DATE OF BIRTH
PLACE OF BIRTH
CITY OF BIRTH
STATE OF BIRTH
CITY OF DEATH
STATE OF DEATH

DATE OF DEATH
TIME OF DEATH
PLACE OF DEATH
CITY OF DEATH
STATE OF DEATH

CAUSE OF DEATH
MANNER OF DEATH
DISEASE OR INJURY
IMMEDIATE CAUSE
MIDDLE CAUSE
REMOTEST CAUSE

EDUCATION
OCCUPATION
MARRIAGE
RELIGION
POLITICAL PARTY

PREVIOUS ILLNESS
PREVIOUS SURGERY
PREVIOUS TRAUMA
PREVIOUS ACCIDENT
PREVIOUS DRUGS

PREVIOUS ALCOHOL
PREVIOUS TOBACCO
PREVIOUS OTHER DRUGS
PREVIOUS OTHER HABITS
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BUREAU V. S.

JAN 31 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

223

CERTIFICATE OF DEATH

00204

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Catonsville Convalescent Home, 315 Ingleside Ave.		d. STREET ADDRESS 944 N. Broadway	
3. NAME OF DECEASED (Type or print) Ella May Blankford		4. DATE OF DEATH Jan. 9, 19 57	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 18, 1882
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper		10b. KIND OF BUSINESS OR INDUSTRY Pa.	
11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Peters		14. MOTHER'S MAIDEN NAME Catherine Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Mrs Curvin Bush, 944 N. Broadway	
17. INFORMANT Mrs Curvin Bush, 944 N. Broadway		Address	
18. CAUSE OF DEATH [Enter only one cause, per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thromboses, cerebral, multiple 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, cerebral, severe DUE TO (c) Unknown		INTERVAL BETWEEN ONSET AND DEATH 72 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Decubitus ulcers, bowel & bladder incontinence		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 57 Hour a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-23 , 19 56 , to 1-9 , 19 57 , that I last saw the deceased alive on 1-7 , 19 57 , and that death occurred at 200 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Stephen Lee Magness M.D.		ADDRESS (Street, city or town, state) 908 FREDERICK RD, Catonsville	
DATE SIGNED 1-11-57			
PHYSICIAN'S NAME (Type) STEPHEN LEE MAGNESS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 12/57	
22c. NAME OF CEMETERY OR CREMATORY Lorraine Park		22d. LOCATION (City, town, or county) (State) Woodlawn Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Witbe		ADDRESS 4101 Edmondson AV	
24a. REC'D BY REGISTRAR JAN 14 '57		24b. REGISTRAR'S SIGNATURE W. L. Smith	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH May 19, 1928	
5. PLACE OF BIRTH Jackson, Mississippi		6. OCCUPATION None		7. MARITAL STATUS Single		8. COLOR White	
9. PLACE OF DEATH Memphis, Tennessee		10. CAUSE OF DEATH Shot		11. MANNER OF DEATH Suicide		12. DATE OF DEATH April 4, 1968	
13. TIME OF DEATH 4:05 PM		14. PLACE OF INTERMENT None		15. NAME OF FUNERAL HOME None		16. SIGNATURE OF DECEASED None	
17. SIGNATURE OF NEXT OF KIN None		18. SIGNATURE OF PHYSICIAN None		19. SIGNATURE OF CORONER None		20. SIGNATURE OF REGISTRAR None	

RECEIVED
JAN 14 1968
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

224
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 40 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Douglas Home (5921 Oldroad)				d. STREET ADDRESS 1 Frederick Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George (NMI) Boro				4. DATE OF DEATH Month Jan. Day 7, Year 1957			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 6, 1899	
9. AGE (In years lost birthday) 57 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY General		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Corrine Bolling (Matron) Douglas Memorial Home			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Mitral Insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive-Arterio-sclerotic Heart Disease DUE TO (c) ?						INTERVAL BETWEEN ONSET AND DEATH 69 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chr. Bronchitis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-30-56 , 19____, to 1-7-57 , 19____, that I last saw the deceased alive on 1-7-57 , 19____, and that death occurred at 4:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 57 Winters Lane, Balto. 28 DATE SIGNED 1-7-57							
ACTUAL SIGNATURE C. F. Maloney		M.D. 57 Winters Lane, Balto. 28					
PHYSICIAN'S NAME (Type) C.F. Maloney, M.D.		57 Winters Lane, Balto. 28. Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 10, 1957		22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Holland Funeral Home				ADDRESS 1631 Druid Hill Av		24a. REC'D BY REGISTRAR DATE JAN 9 '57	
						24b. REGISTRAR'S SIGNATURE W. H. ...	

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		SEX Male	
AGE 45		DATE OF BIRTH Jan 15 1892	
PLACE OF BIRTH Baltimore, Md.		OCCUPATION Carpenter	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
DATE OF DEATH Jan 20 1937		PLACE OF DEATH Home	
SIGNATURE OF PHYSICIAN J. H. Harris		SIGNATURE OF WITNESS J. H. Harris	
SIGNATURE OF DECEASED J. H. Harris		SIGNATURE OF NEXT OF KIN J. H. Harris	
SIGNATURE OF CLERK J. H. Harris		SIGNATURE OF REGISTRAR J. H. Harris	

BUREAU V. S.

JAN 20 1937

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CERTIFICATE OF DEATH

Reg. Dist. No.

22

225

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.D. Owings Mills		c. LENGTH OF STAY IN 1b 3 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.D. Owings Mills			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Winands Rd.				d. STREET ADDRESS Winands Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle F. Last Brackett				4. DATE OF DEATH Month 1 - Day 7 Year 1957			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-21-1906		9. AGE (In years lost birthday) 50 yrs.	IF UNDER 1 YEAR Months 50 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipfitter		10b. KIND OF BUSINESS OR INDUSTRY Beth. Steel		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles P. Brackett				14. MOTHER'S MAIDEN NAME May R. Sprague			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 063-03-5053		17. INFORMANT Address Mrs. Mildred Brackett, Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hodgkins Disease, generalized (c) Few years						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Sep 5, 1955 , to 7 JAN 1957 , that I last saw the deceased alive on 5 JAN 1957 , and that death occurred at 12:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Paul H Royse		M.D. 808 Reisterstown Rd		ADDRESS (Street, city or town, state)		DATE SIGNED	
PHYSICIAN'S NAME (Type) Paul H Royse		M.D. Pikesville 8, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1-10-1957	22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Md.		24a. REC'D BY REGISTRAR JAN 10 1957		24b. REGISTRAR'S SIGNATURE Mary Elmer	

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JAN 10 1957
BUREAU V. S.

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BUREAU V. S.

JAN 10 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00207

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MD. b. COUNTY BALTO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STEVENSON				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STEVENSON			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VILLA JULIE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last SISTER MARGARET IRENE BRADY				4. DATE OF DEATH Month Day Year JAN. 15 1957			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 18, 1873	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER-RET.		10b. KIND OF BUSINESS OR INDUSTRY RELIGIOUS		11. BIRTHPLACE (State or foreign country) NEW JERSEY		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME MICHAEL BRADY				14. MOTHER'S MAIDEN NAME ANNE RYAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Villa Julie Ruess		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Congestion. 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Vascular renal disease. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 6 hrs 1 yr	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 1953 , to Jan 16, 1957 , that I last saw the deceased alive on Jan 15, 1957 , and that death occurred at 9:20 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Harold H. Burns M.D.				ADDRESS (Street, city or town, state) 115 C. Cager St		DATE SIGNED Jan 17, 1957	
PHYSICIAN'S NAME (Type) Harold H. Burns							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-18-57		22c. NAME OF CEMETERY OR CREMATORY TRINITY CONVENT CEM.		22d. LOCATION (City, town, or county) (State) Beltsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Trinity Funeral Home, Catonsville, Md.				24a. REC'D BY REGISTRAR JAN 21 1957		24b. REGISTRAR'S SIGNATURE Mabel Gray	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15, 1912</i>		5. PLACE OF BIRTH <i>Baltimore, Md.</i>	
6. OCCUPATION <i>Teacher</i>		7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>Jan 1, 1940</i>		9. PLACE OF MARRIAGE <i>Baltimore, Md.</i>		10. NAME OF SPOUSE <i>Jane Doe</i>	
11. CAUSE OF DEATH <i>Heart Disease</i>		12. MANNER OF DEATH <i>Natural</i>		13. PLACE OF DEATH <i>Home</i>		14. DATE OF DEATH <i>Jan 20, 1957</i>		15. TIME OF DEATH <i>10:00 AM</i>	
16. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		17. SIGNATURE OF REGISTRAR <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>		19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>	

BUREAU V. S.

JAN 21 1957

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CERTIFICATE OF DEATH

Reg. Dist. No.

41

To be approved by Medical Examiner

1. PLACE OF DEATH
a. COUNTY **Baltimore** MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Eastpoint**

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION **425 Pembroke Blvd.**

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE **Md.** b. COUNTY **Baltimore**

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Eastpoint**

d. STREET ADDRESS **425 Pembroke Blvd**

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) **IDA** First **MAY** Middle **BRIGHT** Last

4. DATE OF DEATH **Jan. 2, 1957** Month **Jan.** Day **2** Year **19**

5. SEX **female** 6. COLOR OR RACE **white** 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH **Jan. 15, 1869** 9. AGE (In years last birthday) **87** yrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **housewife** 10b. KIND OF BUSINESS OR INDUSTRY **at home**

11. BIRTHPLACE (State or foreign country) **Baltimore, Md.** 12. CITIZEN OF WHAT COUNTRY? **U.S.**

13. FATHER'S NAME **Alonzo Thompson** 14. MOTHER'S MAIDEN NAME **unknown**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT **Ethel McKenna, dght, above** Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Arteriosclerotic cardiovascular disease**
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. **9030** (b) DUE TO (c)
CERTIFICATION APPROVED BY **John W. Barnaby** M.D.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE IMMEDIATE CAUSE OF DEATH: **Fracture left hip**

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) **Fell on floor**

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year **25 Oct 1956** Hour **2** p.m. 20d. INJURY OCCURRED While ☐ at work Not while ☒ at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **Home** 20f. (City or town) **Baltimore** (County) **County** (State) **Md**

21. I certify that I attended the deceased from **11 Aug 1952** to **2 Jan 1957**, that I last saw the deceased alive on **2 Jan 1957**, and that death occurred at **5:30** M, from the causes and on the date stated above.

ACTUAL SIGNATURE **John W. Barnaby** M.D. **1231 E North Ave** ADDRESS (Street, city or town, state) DATE SIGNED **4 Jan 57**

PHYSICIAN'S NAME (Type) **JOHN W BARNABY**

22a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 22b. DATE THEREOF **12/7/57** 22c. NAME OF CEMETERY OR CREMATORY **Oak Lawn Cem.** 22d. LOCATION (City, town, or county) **Baltimore, Md.** (State)

23. FUNERAL DIRECTOR'S SIGNATURE **Schimunek Funeral Home, Inc.** ADDRESS **2601-03-05 E. Madison St.** 24a. REC'D BY REGISTRAR **Wm. M. Kelly** 24b. REGISTRAR'S SIGNATURE

BUREAU V. S.

JAN 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

228

CERTIFICATE OF DEATH

Reg. Dist. No.

00209

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>820 N. Wolfe Street</u>			
3. NAME OF DECEASED (Type or print) First <u>OLIVER</u> Middle <u>(NMI)</u> Last <u>BROWN, SR.</u>				4. DATE OF DEATH Month <u>January</u> Day <u>2</u> Year <u>19 57</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>COLORED</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/30/86</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Post Office work</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Weston K. Brown</u>				14. MOTHER'S MAIDEN NAME <u>Annie B. Robins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WWI</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Clin. Rec.Vets.Admin.Hospital,Ft.Howard,Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> <u>421.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CALCIFIC AORTIC DISEASE</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u> <u>UNKNOWN</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Oliguria - Uremia</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>December 31</u> , 19 <u>56</u> , to <u>January 2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/31/56</u> and that death occurred at <u>6:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>VA Hospital</u> DATE SIGNED <u>1/2/57</u> ACTUAL SIGNATURE <u>J. J. Kennedy</u> M.D. PHYSICIAN'S NAME (Type) <u>J. J. KENNEDY, M.D.</u> <u>Fort Howard, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Jan 6/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>William E. Elisham</u>				24a. REC'D BY REGISTRAR DATE <u>1/4/57</u>		24b. REGISTRAR'S SIGNATURE <u>Lawson L. Farley</u>	
MRS ROBERT A. ELLIOTT DAUGHTER LEOON CAROLINE ST. PETERS							

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00210

229

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 1b <u>30 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>5220 Old Frederick Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>STANLEY</u> Middle <u>C</u> Last <u>BROWN</u>				4. DATE OF DEATH Month <u>January</u> Day <u>20</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/23/93</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Weatherstripping Co</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Frederick Brown</u>				14. MOTHER'S MAIDEN NAME <u>Sallie Ann Lilly</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		(If yes, give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>212-03-2803</u>		17. INFORMANT <u>Clin. Rec. Vets. Admin. Hospital, Ft. Howard Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF TONGUE WITH MULTIPLE LUNG ABSCESSSES,</u> <u>141X</u> DETOX <u>RIGHT LUNG</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>DUE TO</u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>December 21, 1956</u> , to <u>January 20, 1957</u> , that I last saw the deceased alive on <u>January 12, 1957</u> , and that death occurred at <u>6:15 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Rolando D. Ponce de Leon</u> M.D.				ADDRESS (Street, city or town, state) <u>Veterans Administration Hospital</u>			
PHYSICIAN'S NAME (Type) <u>ROLANDO D. PONCE DE LEON, M.D.</u>				DATE SIGNED <u>1/21/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-23-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook-Blythe Inc</u> ADDRESS <u>Wm Cook-Blythe Inc, 2009 Harford Rd., Balto., Md.</u>				24a. REC'D BY REGISTRAR <u>JAN 25 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Lawson L. Harley</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00211

CERTIFICATE OF DEATH

Reg. Dist. No.

230

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>			c. LENGTH OF STAY IN 1b <u>Life</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7506 Marks Ave.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Carrie</u> Middle <u>M.</u> Last <u>Bruggman</u>			4. DATE OF DEATH Month <u>January</u> Day <u>2</u> Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 11, 1891</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			13. FATHER'S NAME <u>August Lassahn</u>		
14. MOTHER'S MAIDEN NAME <u>Annie Simon</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>None</u>			17. INFORMANT <u>Mr. Harry C. Bruggman</u> Address <u>7506 Marks Ave.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac decompensation</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary occlusion.</u> DUE TO (c) <u>Arterio Vascular Renal disease</u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u> <u>12 hrs.</u> <u>2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>54</u> , to <u>Jan 2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 2</u> , 19 <u>57</u> , and that death occurred at <u>9 P</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8106 Harford Rd. 14. Md.</u> DATE SIGNED <u>Jan 10 1957</u>					
ACTUAL SIGNATURE <u>Harold H Burns</u> M.D.					
PHYSICIAN'S NAME (Type) <u>Harold H Burns</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 5, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore</u>	
22d. LOCATION (City, town, or county) <u>Baltimore, Md.</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>			24. REC'D BY REGISTRAR <u>Jan 10 1957</u>		
ADDRESS <u>7401 Belair Rd.</u>			24b. REGISTRAR'S SIGNATURE <u>Mrs. L. L. Rejman</u>		

11881

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF DEATH		10. DATE OF DEATH	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF WITNESS		14. SIGNATURE OF DECEASED		15. SIGNATURE OF NEXT OF KIN	
16. SIGNATURE OF CLERK		17. SIGNATURE OF CHIEF CLERK		18. SIGNATURE OF ASSISTANT CLERK		19. SIGNATURE OF DEPUTY CLERK		20. SIGNATURE OF RECORDS CLERK	
21. SIGNATURE OF HEALTH COMMISSIONER		22. SIGNATURE OF ASSISTANT COMMISSIONER		23. SIGNATURE OF DEPUTY COMMISSIONER		24. SIGNATURE OF CLERK		25. SIGNATURE OF CHIEF CLERK	
26. SIGNATURE OF ASSISTANT CLERK		27. SIGNATURE OF DEPUTY CLERK		28. SIGNATURE OF RECORDS CLERK		29. SIGNATURE OF CLERK		30. SIGNATURE OF CHIEF CLERK	
31. SIGNATURE OF ASSISTANT CLERK		32. SIGNATURE OF DEPUTY CLERK		33. SIGNATURE OF RECORDS CLERK		34. SIGNATURE OF CLERK		35. SIGNATURE OF CHIEF CLERK	
36. SIGNATURE OF ASSISTANT CLERK		37. SIGNATURE OF DEPUTY CLERK		38. SIGNATURE OF RECORDS CLERK		39. SIGNATURE OF CLERK		40. SIGNATURE OF CHIEF CLERK	
41. SIGNATURE OF ASSISTANT CLERK		42. SIGNATURE OF DEPUTY CLERK		43. SIGNATURE OF RECORDS CLERK		44. SIGNATURE OF CLERK		45. SIGNATURE OF CHIEF CLERK	
46. SIGNATURE OF ASSISTANT CLERK		47. SIGNATURE OF DEPUTY CLERK		48. SIGNATURE OF RECORDS CLERK		49. SIGNATURE OF CLERK		50. SIGNATURE OF CHIEF CLERK	
51. SIGNATURE OF ASSISTANT CLERK		52. SIGNATURE OF DEPUTY CLERK		53. SIGNATURE OF RECORDS CLERK		54. SIGNATURE OF CLERK		55. SIGNATURE OF CHIEF CLERK	
56. SIGNATURE OF ASSISTANT CLERK		57. SIGNATURE OF DEPUTY CLERK		58. SIGNATURE OF RECORDS CLERK		59. SIGNATURE OF CLERK		60. SIGNATURE OF CHIEF CLERK	
61. SIGNATURE OF ASSISTANT CLERK		62. SIGNATURE OF DEPUTY CLERK		63. SIGNATURE OF RECORDS CLERK		64. SIGNATURE OF CLERK		65. SIGNATURE OF CHIEF CLERK	
66. SIGNATURE OF ASSISTANT CLERK		67. SIGNATURE OF DEPUTY CLERK		68. SIGNATURE OF RECORDS CLERK		69. SIGNATURE OF CLERK		70. SIGNATURE OF CHIEF CLERK	
71. SIGNATURE OF ASSISTANT CLERK		72. SIGNATURE OF DEPUTY CLERK		73. SIGNATURE OF RECORDS CLERK		74. SIGNATURE OF CLERK		75. SIGNATURE OF CHIEF CLERK	
76. SIGNATURE OF ASSISTANT CLERK		77. SIGNATURE OF DEPUTY CLERK		78. SIGNATURE OF RECORDS CLERK		79. SIGNATURE OF CLERK		80. SIGNATURE OF CHIEF CLERK	
81. SIGNATURE OF ASSISTANT CLERK		82. SIGNATURE OF DEPUTY CLERK		83. SIGNATURE OF RECORDS CLERK		84. SIGNATURE OF CLERK		85. SIGNATURE OF CHIEF CLERK	
86. SIGNATURE OF ASSISTANT CLERK		87. SIGNATURE OF DEPUTY CLERK		88. SIGNATURE OF RECORDS CLERK		89. SIGNATURE OF CLERK		90. SIGNATURE OF CHIEF CLERK	
91. SIGNATURE OF ASSISTANT CLERK		92. SIGNATURE OF DEPUTY CLERK		93. SIGNATURE OF RECORDS CLERK		94. SIGNATURE OF CLERK		95. SIGNATURE OF CHIEF CLERK	
96. SIGNATURE OF ASSISTANT CLERK		97. SIGNATURE OF DEPUTY CLERK		98. SIGNATURE OF RECORDS CLERK		99. SIGNATURE OF CLERK		100. SIGNATURE OF CHIEF CLERK	

BUREAU V. 5

JAN 10

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00212

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk 53	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2021 Denbury Drive		d. STREET ADDRESS 2021 Denbury Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WALTER Middle RUSSELL Last BUCK		4. DATE OF DEATH Month Jan. Day 26, Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 18, 1916
9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector		10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Howard Buck		14. MOTHER'S MAIDEN NAME Bessie Stealey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 213-09-4255	
17. INFORMANT Mrs. Thelma Buck		Address 2021 Denbury Drive	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) STRANGULATION (Hanging)			
974x DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hung self from rafters in cellar	
20c. TIME OF INJURY Month, Day, Year 405 1-26 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Dundalk - Baltimore Md	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE M.B. Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) M.B. DAVIS M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 30, 1957	
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn		22d. LOCATION (City, town, or county) (State) Colgate, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home		ADDRESS 2112 Dundalk Ave.	
24a. REC'D BY REGISTRAR DATE 1-30-57		24b. REGISTRAR'S SIGNATURE Wm. Kelly	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

...MEDICAL EXAMINER'S CERTIFICATE OF DEATH
...MAYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 11

BUREAU V. S.

JAN 31 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00213

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

38

231

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Idlewylld				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6516 Beechwood Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EILEEN Middle E. Last BUDDEMEYER				4. DATE OF DEATH Month January Day 23 Year 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 15, 1921	
9. AGE (In years last birthday) 36 35		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Typing (private)				10b. KIND OF BUSINESS OR INDUSTRY Typing		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Gordon L. King				14. MOTHER'S MAIDEN NAME Mary A. Werner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-18-1836		17. INFORMANT Mrs. Kathryn M. Pizza		Address Hyattsville, Md. 5010 - 60th Ave. /	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to Strangulation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Strangled by husband			
20c. TIME OF INJURY Month, Day, Year Hour XX p. m. 1/23 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Baltimore Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE William V. Lovitt, Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/26/57		22c. NAME OF CEMETERY OR CREMATORY Parkwood Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickner & Sons - Balto 17, Md.				24a. REC'D BY REGISTRAR DATE 1-28-57		24b. REGISTRAR'S SIGNATURE Mabel Gray	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

JAN 29 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1c Film G209 1-11-57 et

232

CERTIFICATE OF DEATH

00214

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY (Baltimore City)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 3 1/2 Yrs. 11 Mos. 3 Dns.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City		d. STREET ADDRESS 929 North Hill Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sheppard & Enoch Pratt Hosp. Towson 4, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Rosalie Middle Wolfe Last Buffington		4. DATE OF DEATH Month January Day 3 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 14, 1884
9. AGE (In years lost birthday) 72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Lawrence Wolfe		14. MOTHER'S MAIDEN NAME Annie?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Hospital Records	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis & cerebral hemorrhage 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 days unk	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 30 1957 to Jan 3, 1957 , that I last saw the deceased alive on Jan 2 , 19 57 , and that death occurred at 1:33 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sheppard-Pratt Hosp. Towson 4, Maryland DATE SIGNED Jan 3, 1957			
ACTUAL SIGNATURE Harry M. Murdock		M.D. Sheppard-Pratt Hosp. Towson 4, Maryland	
PHYSICIAN'S NAME (Type) Harry M. Murdock, M. D.		Sheppard-Pratt Hospital, Towson 4, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/5/57	
22c. NAME OF CEMETERY OR CREMATORY Baltimore Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Chas. J. Vickers & Sons - Balto 17 Md		24a. REC'D BY REGISTRAR DATE 1/8/57	
24b. REGISTRAR'S SIGNATURE Metel Gray			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

10-10-57

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		45		Jan 1, 1912	
Place of Birth		Race		Occupation		Usual Residence	
Baltimore, Md.		White		Teacher		Baltimore, Md.	
Cause of Death		Manner of Death		Date of Death		Time of Death	
Heart Disease		Natural		Jan 10, 1957		10:00 AM	
Physician's Signature		Hospital or Place of Death		Name of Hospital		City and State	
[Signature]		St. Mary's Hospital		St. Mary's Hospital		Baltimore, Md.	
Burial or Disposition		Name of Burial Place		City and State		Date of Burial	
Buried		Holy Trinity Church		Baltimore, Md.		Jan 12, 1957	
Signature of Registrar		Name of Registrar		City and State		Date of Registration	
[Signature]		John Doe		Baltimore, Md.		Jan 10, 1957	

BUREAU V. S.

JAN 9 1957

RECEIVED

204 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Halethorpe			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1824 Park Ave.				d. STREET ADDRESS 1824 Park Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last ANNIE E. CAROTHERS				4. DATE OF DEATH Month Day Year Jan. 30 19 57			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 25, 1870	
9. AGE (In years lost birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never Worked				10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Penna.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME James F. Carothers				14. MOTHER'S MAIDEN NAME Clara Isenberg			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) no		17. INFORMANT Address Mr. Joseph H. Carothers - 1824 Park Ave., Hale-			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart disease decomposition 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Heart lesion DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 hr + yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1947 , to Jan 30, 1957 , that I last saw the deceased alive on Jan 30 , 1957, and that death occurred at 11:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 1014 Travis Ave - Balto - Md.							
ACTUAL SIGNATURE Frederick B. Butler				PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 2/1/57		22c. NAME OF CEMETERY OR CREMATORY Greenhill Cem.		22d. LOCATION (City, town, or county) (State) Danville, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Licheney & Sons - Balto.				24a. REC'D BY REGISTRAR DATE B 1 1957			
24b. REGISTRAR'S SIGNATURE Dr. Geo. M. Huffer							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 2 should be filed with the registrar.

FEB 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

233

CERTIFICATE OF DEATH

Reg. Dist. No.

00216

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Milford		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Milford	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3610 Latham Road		d. STREET ADDRESS 3610 Latham Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle Buell Last Chiles		4. DATE OF DEATH Month January Day 17 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 25, 1906
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesmanager		10b. KIND OF BUSINESS OR INDUSTRY Mopar Corp.	
11. BIRTHPLACE (State or foreign country) Perryville, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James A. Chiles		14. MOTHER'S MAIDEN NAME Jennie Clifton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 505-10-2357	
17. INFORMANT Dorothy Jane Chiles - 3610 Latham Road		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease (c) Hypertensive Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 3 HRS 1 YR 8 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-5 , 19 56 , to 1-17 , 19 57 , that I last saw the deceased alive on 1-17 , 19 57 , and that death occurred at 5 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7306 Liberty Road Baltimore, Md. DATE SIGNED 1/17/57			
ACTUAL SIGNATURE B. Stanley Cohen		M.D. 7306 Liberty Road Baltimore, Md.	
PHYSICIAN'S NAME (Type) B. Stanley Cohen, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Removal		22b. DATE THEREOF 1-17-57	
22c. NAME OF CEMETERY OR CREMATORY Bloomfield Cemetery		22d. LOCATION (City, town, or county) (State) Bloomfield, Missouri	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost		24a. REC'D BY REGISTRAR Jan 21 1957	
ADDRESS 4600 Liberty Hghts		24b. REGISTRAR'S SIGNATURE Dr. Jm. Martin	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
MAYNARD		45		M		W		1912		BALTIMORE		BALTIMORE		U.S.A.	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY	
JAN 21 1957		10:30 AM		HOME		BALTIMORE		U.S.A.		HEART DISEASE		NATURAL		CORONARY THROMBOSIS	
OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA	
MANAGER		HIGH SCHOOL		METHODIST		MARRIED		NONE		NONE		NONE		NONE	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK		SIGNATURE OF NURSE		SIGNATURE OF CHAPLAIN	

BUREAU V. S.

JAN 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00217

CERTIFICATE OF DEATH

Reg. Dist. No.

31

234

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn Baltimore 3001-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2120 Southland Rd.				d. STREET ADDRESS 3007 Ferndale Ave.			
3. NAME OF DECEASED (Type or print) First LUCIA Middle COBURN Last COBURN				4. DATE OF DEATH Month January Day 25 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1863 Feb. 26, 1863	9. AGE (In years last birthday) 93 yrs.	IF UNDER 1 YEAR Months 25 Days 19 Hours 57 Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Troy, Vermont	
13. FATHER'S NAME David Gallup				12. CITIZEN OF WHAT COUNTRY? USA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Harry A. Coburn - 3007 Ferndale Ave. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5 days 15 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uraemia						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from January, 1948 , to January, 19 57 , that I last saw the deceased alive on 24 January, 19 57 , and that death occurred at 6:00 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Millard T. Traband, Jr. M.D.				ADDRESS (Street, city or town, state) 5101 Gwynn Oak Avenue, Baltimore, 7, Maryland			
PHYSICIAN'S NAME (Type) Millard T. Traband, Jr. M. D.				DATE SIGNED 26 Jan. 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/28/1957		22c. NAME OF CEMETERY OR CREMATORY Sutton Village Cem.		22d. LOCATION (City, town, or county) (State) Sutton, Vermont	
23. FUNERAL DIRECTOR'S SIGNATURE ELLSWORTH ARMACOST ADDRESS 4600 Liberty Hghts.				24a. REC'D BY REGISTRAR Jan 29 1957		24b. REGISTRAR'S SIGNATURE Dr. H. E. Martens	

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]	
AGE [Faint text]		RACE [Faint text]	
DATE OF BIRTH [Faint text]		PLACE OF BIRTH [Faint text]	
DATE OF DEATH [Faint text]		PLACE OF DEATH [Faint text]	
TIME OF DEATH [Faint text]		CAUSE OF DEATH [Faint text]	
MANNER OF DEATH [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF WITNESS [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF NEXT OF KIN [Faint text]	
SIGNATURE OF BURIAL SOCIETY [Faint text]		SIGNATURE OF FUNERAL HOME [Faint text]	
SIGNATURE OF CHURCH [Faint text]		SIGNATURE OF CEMETERY [Faint text]	
SIGNATURE OF MINISTRY [Faint text]		SIGNATURE OF OTHER [Faint text]	

BUREAU V. S.

JAN 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

235

CERTIFICATE OF DEATH

00218

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Baltimore MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1100 McAdoo Ave.				d. STREET ADDRESS 1100 McAdoo Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First William P. Cole, Sr. Middle Last 				4. DATE OF DEATH Month January Day 22 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 25, 1873		9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William P. Cole				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 		16. SOCIAL SECURITY NO. 		17. INFORMANT Address William P. Cole, Jr. 1100 McAdoo Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE - CORONARY INSUFFICIENCY (b) PULMONARY EDEMA - PNEUMONIA (c) CEREBRO- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 420.1 DUE TO DUE TO DUE TO DUE TO							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/21 , 19 57 , to 1/21 , 19 57 , that I last saw the deceased alive on 1/21 , 19 57 , and that death occurred at 4:30 P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE John H. Shaw				ADDRESS (Street, city or town, state) 5800 Edmonson Ave.			
PHYSICIAN'S NAME (Type) John H. Shaw M.D.				DATE SIGNED 1/23/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF Jan 26, 1957		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Homes, 4210 Belair Rd. Balto.				24a. REC'D BY REGISTRAR AN 25 57		24b. REGISTRAR'S SIGNATURE Perleach	

BUREAU V. S.

JAN 25 1957

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 1 should be detached for use as the burial-transit permit. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00210

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 23 3701.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		d. STREET ADDRESS 1702 Hollin Street	
3. NAME OF DECEASED (Type or print) First William Middle Frederick Last Colehouse		4. DATE OF DEATH Month January Day 6 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10.7.04
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HARRY COLEHOUSE		14. MOTHER'S MAIDEN NAME MARGARET KAYLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES, 1919-1921		16. SOCIAL SECURITY NO. NO	
17. INFORMANT Hospital records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FAR ADVANCED PULMONARY TUBERCULOSIS DUE TO (b) 3 months DUE TO (c) 002X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 3 , 19 57 , to Jan 6 , 19 57 , that I last saw the deceased alive on January 6 , 19 57 , and that death occurred at 7:00 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE William Newcomer M.D.		PHYSICIAN'S NAME (Type) William Newcomer, M.D. Supt. Mt. Wilson, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/9/58	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Stansbury		24a. REC'D BY REGISTRAR JAN 10 1957	
ADDRESS 6411 Windsor Mill Rd		24b. REGISTRAR'S SIGNATURE Dorothy Newell	

700:6 Miller 5021

25

TEST AND TRAIN

100-151000 49944

2F1-815 254

FOR ADVANCED PURCHASE

9.7

JAN 10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00220

237

CERTIFICATE OF DEATH

Reg. Dist. No.

31

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wards Chapel Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Annie</u> First <u>ES.</u> Middle <u>CONNER</u> Last		4. DATE OF DEATH <u>Jan</u> Month <u>19</u> Day <u>1957</u> Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/12/80</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>N. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Kunnert, Fred</u>		14. MOTHER'S MAIDEN NAME <u>St. Ding - Hattie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT Address <u>same</u> <u>Mrs Alfred Stephens (daughter)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>260x</u> DUE TO <u>hypertensive c.v. disease - diabetes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>melittus</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>443x</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 10</u> , 19 <u>53</u> , to <u>present</u> , 19 <u>—</u> , that I last saw the deceased alive on <u>1/18</u> , 19 <u>57</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edwin L Pierpont</u> M.D.		DATE SIGNED <u>1/19/57</u>	
PHYSICIAN'S NAME (Type) <u>Edwin L Pierpont, M.D.</u>		<u>8204 Liberty Rd. Balto 7, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/22/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Balto. National Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Dickens & Sons - Balto 17th</u>		24a. REC'D BY REGISTRAR <u>Dr. Wm. Martin</u>	
ADDRESS		DATE <u>JAN 22 1957</u>	

BUREAU V. S.

JAN 22 1957

RECEIVED

238

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>Montgomery</u> <u>Catonsville</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto 22</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52</u> d. STREET ADDRESS <u>Catonsville Maryland</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>A.</u> (Corneal) <u>Corneal</u>		4. DATE OF DEATH Month <u>January</u> Day <u>14</u> Year <u>1957</u>					
5. SEX <u>F</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-10-1876</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months <u>81</u> Days <u>80</u> Hours <u>80</u> Min. <u>80</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Ben Smith</u>			14. MOTHER'S MAIDEN NAME <u>Susan Smith</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Walter Corneal 6824 Belclaire Rd. Balto 22, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary insufficiency occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic - cardio-vascular disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from <u>June 23, 1955</u> , to <u>January 14, 1957</u> , that I last saw the deceased alive on <u>January 14, 1957</u> , and that death occurred at <u>1:50</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>Stella Wachler</u>		M.D. <u>SPRING GROVE STATE HOSPITAL 1-14-57</u>					
PHYSICIAN'S NAME (Type) <u>Stella Wachler, M. D.</u>		<u>Catonsville 28, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-17-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>DAK HAWN</u>			
22d. LOCATION (City, town, or county) <u>Balto, Co. Md</u>		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Corneal</u>		ADDRESS <u>Balto, Co. Md</u>		24a. REC'D BY REGISTRAR DATE <u>Jan 16 '57</u>			
24b. REGISTRAR'S SIGNATURE <u>W. Corneal</u>		_____					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 16 1957

RECEIVED

239

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CARNEY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2 CARNEY</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9714 MAGLETT RD</u>				d. STREET ADDRESS <u>19714 MAGLETT RD.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>ETHEL</u> First Middle <u>G</u> Last <u>CORSE</u>				4. DATE OF DEATH Month <u>1</u> Day <u>24</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>12-26-1869</u>	9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT Home</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>WM. PURNELL GORDY</u>				14. MOTHER'S MAIDEN NAME <u>HANNIE HOLLAND</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>WALTER B CRANMER SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Right Ovary</u> <u>175X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>6</u>	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan 15</u> , 19 <u>55</u> , to <u>Jan 24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 24</u> , 19 <u>57</u> , and that death occurred at <u>11 A</u> . M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5106 HARFORD ROAD</u> DATE SIGNED <u>Jan 24, 1957</u>							
ACTUAL SIGNATURE <u>L. L. Gordy</u>				M.D. <u>5106 HARFORD ROAD</u>			
PHYSICIAN'S NAME (Type) <u>LYLE L. GORDY</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>PERIAL</u>		22b. DATE THEREOF <u>1/26/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LODON PARK</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>CHAS F. EVANSTON 8802 HARFORD RD</u>				24a. REC'D BY REGISTRAR DATE <u>AN 29 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. A. M. Bacon</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

00223

249

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Items 11, 13, 14 Film G209 1-16-57 et

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>✓</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore,</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mercy Villa-Bellona Ave.</u>		STREET ADDRESS (If rural, give location) <u>4 Upland Road</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Florence</u>	(Middle) <u>Brown</u>	(Last) <u>Cotton</u>
4. DATE OF DEATH	(Month) <u>Jan.</u>	(Day) <u>2,</u>	(Year) <u>1957</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>Dec. 23, 1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>76</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Baltimore Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Louis Brown</u>		14. MOTHER'S MAIDEN NAME <u>Mary Myers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Mrs. Mary Campbell 204 Edgevale Road</u>			

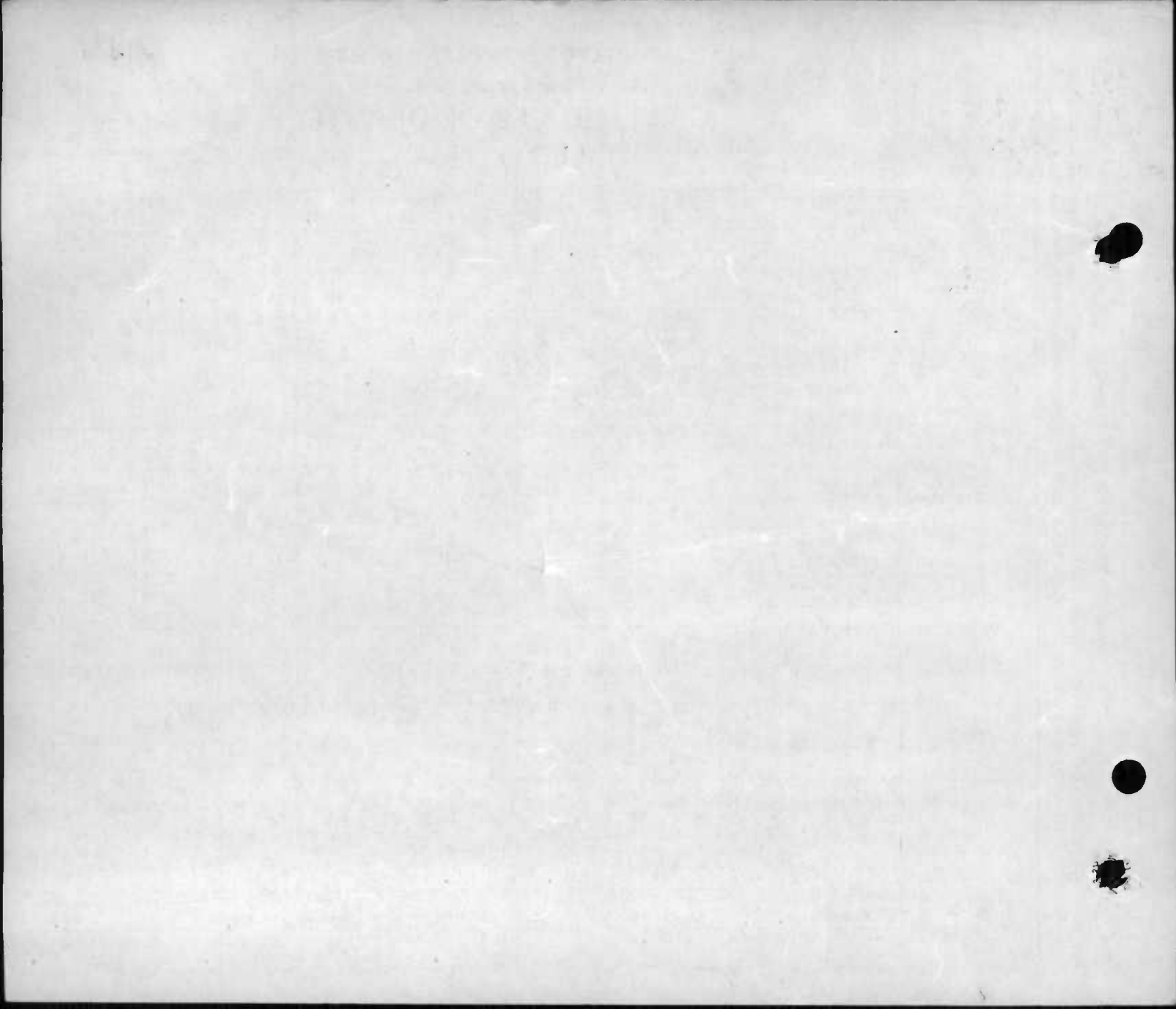
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>Cerebral Vascular Accident</u>			<u>12 hrs</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			<u>10 yrs</u>
(a) <u>Hypertension</u>			<u>12 yrs</u>
(b) <u>Diabetes</u>			
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>47</u> , 19 <u>57</u> , to <u>2 Jan</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 1</u> , 19 <u>57</u> , and that death occurred at <u>10:50 P</u> m., from the causes and on the date stated above.			
SIGNATURE <u>S. Edwin Muller</u>		ADDRESS <u>2 W. Read St.</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Jan. 5, 1957</u>	NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>	LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR <u>John O. Mitchell & Sons Inc. 1900 Rutaw Pl.</u>	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

D. S. C. Muller



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

205

CERTIFICATE OF DEATH

00224

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oak Pk., Halethorpe				c. LENGTH OF STAY IN 1b 51			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oak Park, Halethorpe				d. STREET ADDRESS 1936 Belle Ave.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1936 Belle Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHARLES Middle TAYLOR Last CROUSE				4. DATE OF DEATH Month Jan. Day 21, Year 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 17, 1876	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber				10b. KIND OF BUSINESS OR INDUSTRY Riggs Ditsler		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Joseph A. Crouse				14. MOTHER'S MAIDEN NAME Cassandra Roberts			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. Sarah E. Crouse - 1936 Belle Ave., Halethorpe				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO chron Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) general arteriosclerosis (c) Diabetes mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Coronary heart disease INTERVAL BETWEEN ONSET AND DEATH 2 yrs 7 yrs 1 mo							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 205 , 19 55 , to Jan 21, 19 57 , that I last saw the deceased alive on Jan 21, 19 57 , and that death occurred at 4:15 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5609 Main St Baltimore, Md. DATE SIGNED 1/23/57							
ACTUAL SIGNATURE W. B. Lumbough				PHYSICIAN'S NAME (Type) W. B. Lumbough			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/24/57		22c. NAME OF CEMETERY OR CREMATORY Lorraine Cem.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Chas. J. Pickens & Sons - Balto				ADDRESS Balto		24a. REC'D BY REGISTRAR Dr. Geo. M. Jeffers	
24b. REGISTRAR'S SIGNATURE							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]	
AGE [REDACTED]		DATE OF BIRTH [REDACTED]	
PLACE OF BIRTH [REDACTED]		CITY AND COUNTY OF BIRTH [REDACTED]	
OCCUPATION [REDACTED]		CAUSE OF DEATH [REDACTED]	
MANNER OF DEATH [REDACTED]		MEDICAL HISTORY [REDACTED]	
PRESENT ILLNESS [REDACTED]		PREVIOUS ILLNESS [REDACTED]	
DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]	
PLACE OF DEATH [REDACTED]		CITY AND COUNTY OF DEATH [REDACTED]	
NAME OF PHYSICIAN [REDACTED]		NAME OF NURSE [REDACTED]	
NAME OF FUNERAL HOME [REDACTED]		NAME OF BURIAL PLACE [REDACTED]	
NAME OF NEXT OF KIN [REDACTED]		NAME OF WITNESS [REDACTED]	
NAME OF REGISTRAR [REDACTED]		NAME OF CLERK [REDACTED]	

BUREAU V. 2

JAN 24 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00225

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River		c. LENGTH OF STAY IN 1b 37 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 Middle River			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 50 Rt. 16. Middle River Rd.		d. STREET ADDRESS Box 50 Rt. 16. Middle River Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Maxim Middle Crouse Last Crouse		4. DATE OF DEATH Month January Day 19 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 23, 1894
9. AGE (In years lost birthday) 62 yrs.		IF UNDER 1 YEAR Months 62 Days 62 Hours 62 Min. 62	IF UNDER 24 HRS. Months 62 Days 62 Hours 62 Min. 62
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Barber Shop	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? Russia	
13. FATHER'S NAME Ivan Crouse		14. MOTHER'S MAIDEN NAME Unknown Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mr. Arnold M. Crouse		Address Middle River Box 50 Rt. 16 Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO arteriosclerotic Cardio-Vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 2 yrs DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1 , 1957, to Jan 19 , 1957, that I last saw the deceased alive on Jan 19 , 1957, and that death occurred at 5:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE G.M. Baumgardner M.D.		ADDRESS (Street, city or town, state) Baltimore Md DATE SIGNED 1/19/57	
PHYSICIAN'S NAME (Type) G.M. Baumgardner			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 22, 1957	
22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lovahn Funeral Home		ADDRESS 7401 Belair Rd	
24a. REC'D BY REGISTRAR Jan 22 1957		24b. REGISTRAR'S SIGNATURE Edith Harley	

OVERVIEW

BUREAU

JAN 22 1964

707

1950

BUREAU V. S.

JAN 22 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

242

CERTIFICATE OF DEATH

00226

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>Catonsville - 28 52</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ridgeway Manor</u>		d. STREET ADDRESS <u>115. Prospect Ave</u>	
3. NAME OF DECEASED (Type or print) <u>JOHN F CROWLEY</u>		4. DATE OF DEATH Month <u>1</u> Day <u>22</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-27-1871</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Iron Works</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Jerry Crowley</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs Lillian Crowley - 11 S. Prospect Ave</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SUBACUTE° & ACUTE MYOCARDITIS.</u> <u>431X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>SENILITY° SENILE DEGENERATION.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 MO.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>0</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>0</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>NOV. 25, 1956</u> , to <u>JAN. 22, 1957</u> , that I last saw the deceased alive on <u>JAN. 21, 1957</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>S. Lloyd Johnson</u>		DATE SIGNED <u>6348 FREDERICK ROAD.</u>	
PHYSICIAN'S NAME (Type) <u>S. LLOYD JOHNSON, M.D.</u>		<u>CATONSVILLE, MARYLAND.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>1-25-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Johns</u>	22d. LOCATION (City, town, or county) (State) <u>Seacott City - MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mac Mattis - Catonsville - 28</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 28 57</u>	
ADDRESS <u>Catonsville - 28</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Leach</u>	

BUREAU V.

1957 28 Nov

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the Medical Examiner's Office along with form PM3. Page 5 may be retained for the files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

002236

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>			c. LENGTH OF STAY IN 1b <i>55</i> <i>Towson</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Loch Raven Reservoir</i>			d. STREET ADDRESS <i>1 1632 Aberdeen Road</i>		
3. NAME OF DECEASED (Type or print) <i>Mrs. Mary Frances Cuthbert</i>			4. DATE OF DEATH <i>January 8th 19 57</i>		
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 20, 1920</i>	9. AGE (In years last birthday) <i>36</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			13. FATHER'S NAME <i>Thomas A. Di Natale</i>		
14. MOTHER'S MAIDEN NAME <i>Margaret Politz</i>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT <i>Mr. John G. Cuthbert, 1632 Aberdeen Rd</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>975X</i> DUE TO <i>Drowning</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Sudden</i> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Towson</i>	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Charles F. O'Donnell</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <i>Charles F. O'Donnell</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1/11/1957</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>	22d. LOCATION (City, town, or county) <i>Baltimore, Maryland</i>	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck 5305 Harford Road #14</i>			24a. REC'D BY REGISTRAR <i>JAN 10 1957</i>	24b. REGISTRAR'S SIGNATURE <i>Mabel Gray</i>	

RECEIVED

195 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: <u>Balto</u>		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>DUNDALK</u> MARYLAND	CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Dundalk</u>	STATE <u>MARYLAND</u>	COUNTY <u>BALTO</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3121 LIBERTY PARKWAY</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk - n</u>	
3. NAME OF DECEASED: (First) <u>PIETRO</u> (Middle) <u>MARIA</u> (Last) <u>DACRE</u>		4. DATE OF DEATH: (Month) <u>1</u> (Day) <u>30</u> (Year) <u>1957</u>	
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>1-25-1885</u>
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Construction</u>		10b. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday: <u>72</u> yrs. Months Days Hours Min.
13. FATHER'S NAME: <u>ANTHONY DACRE</u>		14. MOTHER'S MAIDEN NAME: <u>MARIA PARDO</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>7716 BAGLEY AVE</u>	
17. INFORMANT & ADDRESS: <u>FRANK DACRE</u>			

18. MEDICAL CERTIFICATION		Interval Between Onset and Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Hypertensive Cardio Vascular Disease</u>		<u>5 yrs</u>
Antecedent causes (s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO		
(c)		
11. OTHER SIGNIFICANT CONDITIONS		
Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>Jan 30</u> , 19 <u>57</u> , to <u>Jan 30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 30</u> , 19 <u>57</u> , and that death occurred at <u>8:15 AM</u> , from the causes and on the date stated above.		
SIGNATURE (Degree or title) <u>W. J. Dippe</u> ADDRESS <u>6800 Morningstar Ln - Dundalk Md 21222</u> DATE SIGNED <u>1/31/57</u>		
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<u>BURIAL</u>	<u>FEB 2 1957</u>	<u>MAT. HOLY REDEEMER</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR
<u>2/1/57</u>	<u>W. J. Dippe</u>	<u>WENDELL J. DIPPEL</u>
		ADDRESS <u>3125 Highland Ave</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES

DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

WASHINGTON, D. C.

OFFICE OF THE ASSISTANT ATTORNEY GENERAL

WASHINGTON, D. C.

UNITED STATES

DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

WASHINGTON, D. C.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>				c. LENGTH OF STAY IN 1b <u>8 mos.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WEST INVERNESS</u>			
				d. STREET ADDRESS <u>18501 KAVANAUGH Rd</u>			
3. NAME OF DECEASED (Type or print) <u>GERALDINE LYNN DAYTON</u>				4. DATE OF DEATH <u>JANUARY 19 1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 7 1946</u>	
				9. AGE (In years last birthday) <u>10</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY <u>Student</u>			
				11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>			
				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>JACK M. DAYTON</u>				14. MOTHER'S MAIDEN NAME <u>GERALDINE COX</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)			
				17. INFORMANT <u>GERALDINE DAYTON</u> Address <u>Dundalk, Md</u>			
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DROWNING</u> <u>929.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (c) <u></u> DUE TO (a) <u></u> (b) <u></u> (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Free Fall from Sea in Sea Creek</u>			
20c. TIME OF INJURY <u>1:45</u> p.m. <u>1-19-57</u>				20d. INJURY OCCURRED <u>While at work</u> <input checked="" type="checkbox"/> <u>Not while at work</u> <input type="checkbox"/>			
				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Sea Creek</u>			
				20f. (City or town) <u>MD Dundalk or Baltimore</u> (County) <u></u> (State) <u>Md</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>M. B. Davis</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>M-B. DAVIS M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Jan. 23, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Philos Cem.</u>		22d. LOCATION (City, town, or county) <u>WESTERNPORT MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E.S. [illegible]</u> ADDRESS <u>Westernport, Md</u>				24a. REC'D BY REGISTRAR <u>DATE 25 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Wm. Kelly</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED
JAN 25 1957

JAN 25 1957

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upperco			c. LENGTH OF STAY IN 1b 93 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upperco		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Fringer Road				d. STREET ADDRESS Fringer Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clara Middle E. Last Deets				4. DATE OF DEATH Month Jan. Day 18 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 2, 1863	
9. AGE (In years last birthday) 93 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Myers				14. MOTHER'S MAIDEN NAME Emily Laudenslauger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Earl Dietz, Upperco Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOCLEROTIC C.V. DISEASE DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 12 HRS. YEARS
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Martin E. Strobel M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) D.D. Capes				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 21, 1957		22c. NAME OF CEMETERY OR CREMATORY St. Paul		22d. LOCATION (City, town, or county) (State) Balto. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Edwin C. Tipton Hampstead, Md.				24a. REC'D BY REGISTRAR DATE 1-19-57		24b. REGISTRAR'S SIGNATURE Mary B. Eline	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Marital Status		Occupation	
James H. Jones		45		Male		White		Married		Teacher	
Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Examiner		Signature of Coroner	
Jan. 15, 1957		Home		Heart Disease		Natural		[Signature]		[Signature]	
Time of Death		Place of Burial		Burial Place		Burial Date		Burial Time		Burial Place	
10:30 AM		Home		Home		Jan. 16, 1957		10:30 AM		Home	

BUREAU V. S.

JAN 22 1957

RECEIVED

Date of Report		Signature of Reporter		Signature of Coroner	
Jan. 17, 1957		[Signature]		[Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the funeral director. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00231

245

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City 3401-4</u>			
c. LENGTH OF STAY IN 1b <u>4yr3mth9dys</u>				d. STREET ADDRESS <u>946 Brunswick St. - Balto. 23</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>DeFord</u> Last <u>DeFord</u>			4. DATE OF DEATH Month <u>January</u> Day <u>16</u> Year <u>19 57</u>				
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>February 1, 1891</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>butcher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>Nebraska</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George DeFord</u>				14. MOTHER'S MAIDEN NAME <u>Sarah DeFord</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetes mellitus</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <u>Amputation of left leg due to diabetic gangrene</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12. 5</u> , 19 <u>56</u> , to <u>1. 16</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1. 16</u> , 19 <u>57</u> , and that death occurred at <u>5.50a.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Spring Grove Hospital Catonsville 28</u> DATE SIGNED <u>1/16/57</u>							
ACTUAL SIGNATURE <u>Rena Becker</u> M.D. <u>Spring Grove Hospital Catonsville 28</u>				PHYSICIAN'S NAME (Type) <u>Rena Becker, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>January 21-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ellsworth Armacost</u>				24a. REC'D BY REGISTRAR <u>W. H. Smith</u> DATE <u>JAN 21 '57</u>		24b. REGISTRAR'S SIGNATURE	

ELLSWORTH ARMACOST 4600 Liberty Heights Ave.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES J. JONES		45		M		W		1910		NEW YORK	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION	
JAN 21 1957		NEW YORK		HEART DISEASE		NATURAL		FARMER		HIGH SCHOOL	
TIME OF DEATH		HOURS		MINUTES		P.M.		TEMPERATURE		PULSE	
10:00		10		00		P.M.		98.6		60	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF JUDGE	
I hereby certify that the above is a true and correct statement of the facts as stated on the certificate of death.		I hereby certify that the above is a true and correct statement of the facts as stated on the certificate of death.		I hereby certify that the above is a true and correct statement of the facts as stated on the certificate of death.		I hereby certify that the above is a true and correct statement of the facts as stated on the certificate of death.		I hereby certify that the above is a true and correct statement of the facts as stated on the certificate of death.		I hereby certify that the above is a true and correct statement of the facts as stated on the certificate of death.	
JAMES J. JONES		JAMES J. JONES		JAMES J. JONES		JAMES J. JONES		JAMES J. JONES		JAMES J. JONES	
JAN 21 1957		JAN 21 1957		JAN 21 1957		JAN 21 1957		JAN 21 1957		JAN 21 1957	

BUREAU V. 2

JAN 21 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

246

CERTIFICATE OF DEATH

00232

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8551 Phila. Rd.		d. STREET ADDRESS 8551 Phila. Rd.	
3. NAME OF DECEASED (Type or print) MARY First Diegel Middle Diesel Last		4. DATE OF DEATH JAN 14 1957 Month 14 Day 1957 Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-14-1875
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR: Months 14 Days 14 Hours 14 Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Balto. Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME August Kahler	
14. MOTHER'S MAIDEN NAME Mary Klein		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. William J. Diegel Address 8551 Phila. Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Arterio sclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) Sudden 5 yrs		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year 19 Hour o. ft. p. m.	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from JAN 1 1956 to JAN 14 1957 , that I last saw the deceased alive on JAN 13 1957 , and that death occurred at 12:05 AM , from the causes and on the date stated above.	
ACTUAL SIGNATURE W. B. Baumgardner M.D. ADDRESS (Street, city or town, state) Baltimore Md		DATE SIGNED 1/14/57	
PHYSICIAN'S NAME (Type)		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 1-17-1957		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer	
22d. LOCATION (City, town, or county) (State) Baltimore Md.		23. FUNERAL DIRECTOR'S SIGNATURE Lorraine Funeral Home ADDRESS 2701 Belair Ave	
24a. RECORDING REGISTRAR JAN 18 1957 DATE		24b. REGISTRAR'S SIGNATURE Edith Hurley	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

NAME OF DECEASED MARY V. Dwyer		DATE OF BIRTH 1900		PLACE OF BIRTH NEW YORK	
DATE OF DEATH 1957		PLACE OF DEATH NEW YORK		CAUSE OF DEATH HEART DISEASE	
OCCUPATION HOUSEWIFE		MARRIAGE 1920		SPOUSE JOHN Dwyer	
EDUCATION 8th Grade		RELIGION Roman Catholic		BAPTISM Yes	
MILITARY SERVICE None		PREVIOUS ILLNESS None		HISTORY OF DRUGS None	
MANNER OF DEATH Natural		PLACE OF INTERMENT St. Mary's Cemetery		DATE OF INTERMENT 1957	
SIGNATURE OF DECEASED MARY V. Dwyer		SIGNATURE OF WITNESS John Dwyer		SIGNATURE OF MINISTER Rev. J. J. ...	
DATE OF SIGNATURE 1957		DATE OF SIGNATURE 1957		DATE OF SIGNATURE 1957	

BUREAU V. S.

JAN 16 1957

RECEIVED

247

CERTIFICATE OF DEATH

00233

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3501-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Caton Ridge Nursing Home		d. STREET ADDRESS 3000 E. Baltimore St.	
3. NAME OF DECEASED (Type or print) Lillian E. Dunlap		4. DATE OF DEATH Month Jan. Day 27 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 10, 1884
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Louis Riefner		14. MOTHER'S MAIDEN NAME ? Gleitsman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Frank T. Dunlap		Address 3501 Elm Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crown Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 4 days unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1/14 , 19 57 , to 1/27 , 19 57 , that I last saw the deceased alive on 1/25 , 19 57 , and that death occurred at 5:18 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Cliff Ratliff Jr.		ADDRESS (Street, city or town, state) DATE SIGNED 4605 Edmondson Ave 1/28/57	
PHYSICIAN'S NAME (Type) CLIFF RATLIFF JR.		4605 EDMONDSON AVE	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 30, 1957	22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran - 3000 E.		ADDRESS Baltimore St.	
24a. REC'D BY REGISTRAR JAN 30 57		24b. REGISTRAR'S SIGNATURE W. H. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE, MD

FILE NO.

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
John A. Smith		Jan. 15, 1900		New York, N.Y.	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE	
Married		Jan. 20, 1920		New York, N.Y.	
NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
John A. Smith		Jan. 25, 1957		Baltimore, Md.	
MANNER OF DEATH		CAUSE OF DEATH		PLACE OF DEATH	
Natural		Heart Disease		Baltimore, Md.	
NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
John A. Smith		Jan. 25, 1957		Baltimore, Md.	
MANNER OF DEATH		CAUSE OF DEATH		PLACE OF DEATH	
Natural		Heart Disease		Baltimore, Md.	

BUREAU V. 2

JAN 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00234

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Balto			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hydes Md				c. LENGTH OF STAY IN TB 2 mos			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUNSHINE AVE Hydes Md				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Alva Middle Wilmont Last Ehrefeld				4. DATE OF DEATH Month Jan Day 3 Year 1957			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 2, 1889	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months 67 Days 67 Hours 67 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Belmar Corp?				10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Penn (ALTONA)	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —				16. SOCIAL SECURITY NO. 216-10-5547		17. INFORMANT Shirley M. Fites Address McCamel Rd Parkton Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis, generalized, advanced DUE TO (c) Diabetes mellitus INTERVAL BETWEEN ONSET AND DEATH 1 hr undet undet							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John C. Hyle				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John C. Hyle MD				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		1/6/57		Fork M.E.		Fork Md	
23. FUNERAL DIRECTOR'S SIGNATURE PAUL H. HEEMANN				24a. REC'D BY REGISTRAR 6667 HALLFORD RD			
				24b. REGISTRAR'S SIGNATURE Dr. Walter Hammett			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

IN WYAND STATE DEPARTMENT OF HEALTH - JAILHOUSE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. SIGNATURE OF EXAMINER		14. SIGNATURE OF WITNESS		15. SIGNATURE OF JURY	
16. SIGNATURE OF JURY		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY		19. SIGNATURE OF JURY		20. SIGNATURE OF JURY	
21. SIGNATURE OF JURY		22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY		25. SIGNATURE OF JURY	
26. SIGNATURE OF JURY		27. SIGNATURE OF JURY		28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY		34. SIGNATURE OF JURY		35. SIGNATURE OF JURY	
36. SIGNATURE OF JURY		37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY		40. SIGNATURE OF JURY	
41. SIGNATURE OF JURY		42. SIGNATURE OF JURY		43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY		49. SIGNATURE OF JURY		50. SIGNATURE OF JURY	
51. SIGNATURE OF JURY		52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY		55. SIGNATURE OF JURY	
56. SIGNATURE OF JURY		57. SIGNATURE OF JURY		58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY		64. SIGNATURE OF JURY		65. SIGNATURE OF JURY	
66. SIGNATURE OF JURY		67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY		70. SIGNATURE OF JURY	
71. SIGNATURE OF JURY		72. SIGNATURE OF JURY		73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY		79. SIGNATURE OF JURY		80. SIGNATURE OF JURY	
81. SIGNATURE OF JURY		82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY		85. SIGNATURE OF JURY	
86. SIGNATURE OF JURY		87. SIGNATURE OF JURY		88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY		94. SIGNATURE OF JURY		95. SIGNATURE OF JURY	
96. SIGNATURE OF JURY		97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY		100. SIGNATURE OF JURY	

BUREAU V. S.

JAN 9 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 249
 CERTIFICATE OF DEATH

00235

38

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE MD.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> c. LENGTH OF STAY IN 1b <u>6 MOS.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>500 PARK AVENUE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 TOWSON 4</u> d. STREET ADDRESS <u>500 PARK AVENUE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>MARIE MARGARET EIERMAN</u>		4. DATE OF DEATH Month <u>JAN.</u> Day <u>15</u> Year <u>1957</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 5-1890</u>		9. AGE (In years last birthday) <u>66</u> yrs. <u>7</u> Months <u>15</u> Days <u>15</u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Maker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>House Keeping</u>				11. BIRTHPLACE (State or foreign country) <u>Ind.</u>				12. CITIZEN OF WHAT COUNTRY? <u>Baltimore</u>			
13. FATHER'S NAME <u>Henry Krumm</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Kahl</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or department service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Harry Krumm</u> Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>metastatic, Cerebral Carcinoma</u> <u>199.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastasis from Pelvic Organ</u> DUE TO (c) <u>Operation Oct 1890</u>												INTERVAL BETWEEN ONSET AND DEATH <u>Oct 5 to 1-15-1957</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Aug 10, 1954</u> to <u>Jan 14, 1957</u> that I last saw the deceased alive on <u>Jan 14, 1957</u> , and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above.															
ACTUAL SIGNATURE <u>C. B. ENSOR</u>				M.D. <u>7201 York Rd., Balto 12 Md</u>				ADDRESS (Street, city or town, state)				DATE SIGNED <u>1-15-57</u>			
PHYSICIAN'S NAME (Type) <u>C. B. ENSOR</u>															
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>1/18/57</u>				22c. NAME OF CEMETERY OR CREMATORY <u>DRUID RIDGE CEMETERY</u>				22d. LOCATION (City, town, or county) (State) <u>PIKESVILLE MARYLAND.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>HENRY SANDER & SONS INC. BALTIMORE MD.</u> ADDRESS <u>500 Park Avenue</u>															
24a. REC'D BY REGISTRAR <u>DATE JAN 21 1957</u>				24b. REGISTRAR'S SIGNATURE <u>Mabel Gray</u>											

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

FILE NO.

MARYLAND

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

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BUREAU V. 2

JAN 21 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial-transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00236

44

Reg. Dist. No.

250 CERTIFICATE OF DEATH

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO.</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN <u>DUNDALK</u>		LENGTH OF STAY (In this place) <u>16 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>DUNDALK 22</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>24 SEABRIGHT AVE.</u>				STREET ADDRESS (If rural give location) <u>24 SEABRIGHT AVE</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>GEORGE WILLIAM EISENBACH</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>1-14-1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>DEC. 26, 1883</u>	9. AGE last birthday <u>73</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MECHANIC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PRINT WORK</u>		11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GAM EISENBACH</u>				14. MOTHER'S MAIDEN NAME <u>ANNA SCHIFFER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>2-6019349A</u>		17. INFORMANT & ADDRESS <u>FLORENCE S. EISENBACH</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
156.1 IMMEDIATE CAUSE (A) <u>HEPATOMA</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 MO.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>19.50</u> <u>Jan 14</u> , to <u>19.57</u> , that I last saw the deceased alive on <u>Jan 14</u> , 19.57 , and that death occurred at <u>8:15 A</u> M, from the causes and on the date stated above. SIGNATURE <u>Stephen A. Mockenale</u> M.D. <u>6714 Holabird Ave</u> DATE SIGNED <u>1-15-57</u>							
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>1-17-57</u>		NAME OF CEMETERY OR CREMATORY <u>CHURCH LAWN</u>		LOCATION (City, town, or county) (State) <u>BALTO. Co. Md</u>	
24. REC'D BY REGISTRAR <u>JAN 16 1957</u>		REGISTRAR'S SIGNATURE <u>Wm. M. Kelly, Jr.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Decker Beahy, Dundalk, Md</u>		ADDRESS	

10838

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

CERTIFICATE OF DEATH

Form No. 10

ALL DEATHS MUST BE REPORTED TO THE HEALTH DEPARTMENT

MARYLAND

CITY OF BALTIMORE

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS OTHER

PREVIOUS UNKNOWN

PREVIOUS UNRECORDED

PREVIOUS UNREPORTED

PREVIOUS UNCLASSIFIED

PREVIOUS UNDETERMINED

PREVIOUS UNEXPLAINED

PREVIOUS UNIDENTIFIED

PREVIOUS UNRECORDED

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BUREAU V. S.

JAN 16 1917

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours, after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

251

CERTIFICATE OF DEATH

00237

Reg. Dist. No.

37

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home, Chattalonnee Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Hobson</u> Last <u>Elder</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>8</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/5/1862</u>
9. AGE (In years last birthday) <u>94</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert North Elder</u>		14. MOTHER'S MAIDEN NAME <u>Susan Gordon Voss</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Edward B. Whitman, Chattalannee, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Arterio-sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days.</u> <u>15 yrs.</u> <u>20 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 7</u> , 19 <u>57</u> , to <u>Jan 8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 7</u> , 19 <u>57</u> , and that death occurred at <u>5:06 A.M.</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>Palmer F. Williams</u> M.D.		<u>1725 Reisterstown Rd</u> <u>1/8/57</u>	
PHYSICIAN'S NAME (Type) <u>PALMER F. WILLIAMS</u>		<u>Pikesville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 10, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Thomas Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Garrison Forrest, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank A. Newell</u>		ADDRESS <u>Pikesville, Md.</u>	
24a. REC'D BY REGISTRAR <u>Jan 10 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dorothy Newell</u>	

STATE DEPARTMENT OF HEALTH - BALTIMORE 18
CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		JAN 15 1880		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
1234 E. BALTIMORE ST.		LABORER		HEART DISEASE		NATURAL		JAN 20 1925		BALTIMORE, MD.	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
JAN 20 1925		BALTIMORE, MD.		HEART DISEASE		NATURAL		JAN 20 1925		BALTIMORE, MD.	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
JAN 20 1925		BALTIMORE, MD.		HEART DISEASE		NATURAL		JAN 20 1925		BALTIMORE, MD.	

RECEIVED
 JAN 10 1925
 BUREAU V. S.

252
CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sparrows Pt.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sparrows Point</i>	
c. LENGTH OF STAY IN 1b <i>60 yrs</i>		d. STREET ADDRESS <i>1502-C-CH-</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>at home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Edgar May Elford</i>		4. DATE OF DEATH <i>Jan-31-57</i> 19 <i>57</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May-21-1890</i>
9. AGE (In years last birthday) <i>36</i> yrs.		10. IF UNDER 1 YEAR <i>19</i> Months <i>31</i> Days <i>17</i> Hours <i>57</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>Stamford Conn</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Cornelius B Doty</i>		14. MOTHER'S MAIDEN NAME <i>Rebecca J Ferguson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>No</i>	
17. INFORMANT <i>Mr. Elford</i>		Address <i>1502-C-CH-</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic St. Disease</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i> <i>6 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>July</i> 19 <i>50</i> , to <i>Jan 31</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>Jan 31</i> , 19 <i>57</i> , and that death occurred at <i>11:00 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. T. Means</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>2-1-57</i>	
PHYSICIAN'S NAME (Type) <i>J. T. Means</i>		M.D. <i>502 St. B. Ct. H. Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremated Feb 2/57</i>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <i>Greenwood</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Stewart M. ...</i>		ADDRESS <i>102 W. ...</i>	
24a. REC'D BY REGISTRAR <i>31</i>		24b. REGISTRAR'S SIGNATURE <i>Dawson L. Farber</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

BUREAU V. S.

FEB 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00239

253

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baldwin		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fork Rd.		e. STREET ADDRESS Fork Rd.	
3. NAME OF DECEASED (Type or print) First Henry Middle F. Last Emmel		4. DATE OF DEATH Month January Day 21 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-30-1884
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Balto. Co. Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME George Emmel	
14. MOTHER'S MAIDEN NAME Mary E. Laubach		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 218-14-9382A		17. INFORMANT Address Mrs. Caroline A. Emmel Fork Rd. Baldwin, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 day		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from Jan 21, 1957 to Jan 21, 1957 that I last saw the deceased alive on Jan 21, 1957 , and that death occurred at 8:14 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Baldwin DATE SIGNED Jan 21-57	
ACTUAL SIGNATURE Halter Hammitt M.D.		PHYSICIAN'S NAME (Type) Halter Hammitt	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 24, 1957	22c. NAME OF CEMETERY OR CREMATORY Parkwood	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home ADDRESS 7401 Belair Rd.		24a. REC'D BY REGISTRAR JAN 22 1957	24b. REGISTRAR'S SIGNATURE Dr. Halter Hammitt

BUREAU V. S.

JAN 22 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00240

206

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARBUTUS		c. LENGTH OF STAY IN 1b 10 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4208 Leeds Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CARRIE M. ENGELMANN		4. DATE OF DEATH Month Day Year Jan. 25, 1957 19	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 12, 1866
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME ----- Fink		14. MOTHER'S MAIDEN NAME Margaret -----	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Address Florence Rosenberger, 4208 Leeds Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) ?		INTERVAL BETWEEN ONSET AND DEATH 12 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1956 , to Jan 25, 1957 , that I last saw the deceased alive on Jan 18, 1957 , and that death occurred at 10:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 400 Wilkens Ave Pikesville Md DATE SIGNED Jan 27, 1957 ACTUAL SIGNATURE Earl Pass, MD M.D. 400 Wilkens Ave Pikesville Md Jan 27, 1957 PHYSICIAN'S NAME (Type) J. EARL PASS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 1-29-57	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard, 4107 Wilkens Ave.		24a. REC'D BY REGISTRAR JAN 30 1957 24b. REGISTRAR'S SIGNATURE Dr. H. M. Kieffer	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. PLACE OF DEATH [Faint text]</p>	
<p>7. OCCUPATION [Faint text]</p>		<p>8. CAUSE OF DEATH [Faint text]</p>	
<p>9. MANNER OF DEATH [Faint text]</p>		<p>10. MEDICAL HISTORY [Faint text]</p>	
<p>11. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>12. SIGNATURE OF REGISTRAR [Faint text]</p>	
<p>13. DATE OF DEATH [Faint text]</p>		<p>14. TIME OF DEATH [Faint text]</p>	
<p>15. PLACE OF INTERMENT [Faint text]</p>		<p>16. NAME OF INTERMENT PLACE [Faint text]</p>	
<p>17. SIGNATURE OF INTERMENT PLACE [Faint text]</p>		<p>18. DATE OF INTERMENT [Faint text]</p>	

BUREAU V. S.

JAN 30 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it is to be signed by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00241

CERTIFICATE OF DEATH

Reg. Dist. No. 38

254

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 55	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8603 Goetze Avenue		d. STREET ADDRESS 8603 Goetze Avenue	
3. NAME OF DECEASED (Type or print) First ELMER Middle T. Last ENGLISH		4. DATE OF DEATH Month January Day 18, Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 10, 1888
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter Contractor		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James W. English	
14. MOTHER'S MAIDEN NAME June D. Johnson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW I	
16. SOCIAL SECURITY NO. WW I		17. INFORMANT Family records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO Carcinoma of lungs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 163X DUE TO (c) 163X			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1/15 , 19 55 , to 1/18 , 19 57 , that I last saw the deceased alive on 4/18 , 19 27 , and that death occurred at 2:50 P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Gordon M. Gray		ADDRESS (Street, city or town, state) 9523 Jack Raven Blvd Towson 4 MD	
PHYSICIAN'S NAME (Type) GORDON GRAU		DATE SIGNED 1/17/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 21, 1957	22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park	22d. LOCATION (City, town, or county) (State) Parkville, Maryland
23a. FUNERAL DIRECTOR'S SIGNATURE John Burns Sons		ADDRESS Towson, Maryland	
24a. REC'D BY REGISTRAR Jan. 20, 1957		24b. REGISTRAR'S SIGNATURE Mabel C. Gray	

JAN 22 1957

REVISED

255

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u>		<u>BALTIMORE CITY</u> COUNTY	
CITY (If outside corporate limits, write OR and give nearest town) <u>TOWSON</u>		RURAL LENGTH OF STAY (in this place) <u>2 YRS.</u>		CITY (If outside corporate limits, write OR and give nearest town) <u>BALTIMORE 12</u>		Xb TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>13 SHEPARD + ENOCH MATT NOX</u>				STREET ADDRESS (If rural give location) <u>503 CASTLE DRIVE</u>			
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>WILLIAM DEMAIRELLE FRASER.</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>1 - 15 19 57</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWED</u>	8. DATE OF BIRTH: <u>10-31-02</u>	9. AGE last birthday: <u>54</u> yrs.	10. IF UNDER 1 YEAR: Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>REG. NURSE.</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>HOSPITAL</u>		11. BIRTHPLACE (State or foreign country): <u>RHODE ISLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME: <u>(UNKNOWN) - FRASER.</u>			
14. MOTHER'S MAIDEN NAME: <u>BELLE FRASER</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY No.: <u>037-18-5857</u>				17. INFORMANT & ADDRESS: <u>Mrs. Wm. Fraser 503 Castle Drive Baltimore</u>			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
420.1 Immediate cause (a) <u>Coronary occlusion</u>		<u>immediate</u>
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>none known.</u>		
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none known</u>		
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY ? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-15, 1957, to 1-15, 1957, that I last saw the deceased alive on 1-15, 1957, and that death occurred at 9:05 AM, from the causes and on the date stated above.

SIGNATURE (Degree or title) <u>William H. Edwards, Jr. M.D.</u>		ADDRESS <u>Box 6815 Towson - 9 Md. 1-15-57</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL (Special)</u>	DATE THEREOF <u>JAN. 15, 1956</u>	NAME OF CEMETERY OR CREMATORY <u>DRABBLE-SHERMAN E.H.</u>	LOCATION (City, town, or county) (State) <u>PROVIDENCE, R.I.</u>
DATE REC'D BY LOCAL REGISTRAR <u>Jan. 15, 1957</u>	REGISTRAR'S SIGNATURE <u>Mabel C. Gray</u>	24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Md.</u>	ADDRESS <u>Deputy Medical Examiner, Dr. Rella Hudson, notified 1-15-57.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. B.

JAN 18 1957

RECEIVED

FOR DEPOSIT ONLY - JAN 18 1957

255

CERTIFICATE OF DEATH

Reg. Dist. No.

190

1. PLACE OF DEATH o. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Rd.				d. STREET ADDRESS Montgomery Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First CHARLES Middle E. Last FREBURGER				4. DATE OF DEATH Month Jan. Day 26, Year 1957			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 11, 1868	9. AGE (In years lost birthday) 88 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Chief Clerk				10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (State or foreign country) Md.	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Freburger				14. MOTHER'S MAIDEN NAME Josephine -			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -		17. INFORMANT Mrs. Ruth E. Tracey - 1432 Girard St., N.W. DC		Address Washington 9,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart coronary occlusion 420.1 DUE TO Myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial infarction (c) Myocardial infarction							INTERVAL BETWEEN ONSET AND DEATH 2 hrs 29 hrs 5 hrs 10 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from July , 19 53 , to Jan 26 , 19 57 , that I last saw the deceased alive on Jan 26 , 19 57 , and that death occurred at 9:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature] M.D.				ADDRESS (Street, city or town, state) 1609 Main St. Balt., Md.			
DATE SIGNED 1/29/57							
PHYSICIAN'S NAME (Type) Elkridge 27 Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/29/57		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Balt., Md.				24a. REC'D BY REGISTRAR 1-28-57		24b. REGISTRAR'S SIGNATURE E. Bird Williams	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

The full name

JAN 29 1957

RECEIVED

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00244

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Inverness</u>		c. LENGTH OF STAY IN 1b <u>West Inverness</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS <u>8446 Kavanagh Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Valerie Michele Leburger</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>19</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Dec 25 1946</u>
9. AGE (In years last birthday) <u>10</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		12. KIND OF BUSINESS OR INDUSTRY <u>School girl</u>	
13. BIRTHPLACE (State or foreign country) <u>Md</u>		14. CITIZEN OF WHAT COUNTRY	
15. FATHER'S NAME <u>Jacob H Leburger Jr</u>		16. MOTHER'S MAIDEN NAME <u>Sarah Robinson</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		18. SOCIAL SECURITY NO. <u> </u>	
19. INFORMANT <u>Jacob H Leburger</u>		20. ADDRESS <u>8446 Kavanagh Rd</u>	
21. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DROWNING</u> <u>929.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
22a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		23. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell thru log into Bear Creek</u>	
24. TIME OF INJURY Month, Day, Year <u>1-19-57</u>		25. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
26. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Bear Creek</u>		27. (City or town) <u>Dundalk - near Baltimore - Md</u>	
28. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
29. ACTUAL SIGNATURE <u>M. B. Davis</u>		30. M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
31. EXAMINER'S NAME (Type) <u>M. B. DAVIS M.D.</u>		32. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
33. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		34. DATE SIGNED <u>1/20/57</u>	
35. 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		36. 22b. DATE THEREOF <u>Jan 22/57</u>	
37. 22c. NAME OF CEMETERY OR CREMATORY <u>Balto Cem</u>		38. 22d. LOCATION (City, town, or county) <u>Baltimore</u> (State) <u> </u>	
39. 23. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home</u>		40. 24. ADDRESS <u>2112 Dundalk Rd</u>	
41. 25. REC'D BY REGISTRAR <u>AN 22 1957</u>		42. 26. REGISTRAR'S SIGNATURE <u>Wm. Kelly</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		COUNTY	
CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT	
SIGNATURE OF EXAMINER		DATE		TIME		PLACE		CITY	
SIGNATURE OF WITNESS		DATE		TIME		PLACE		CITY	
SIGNATURE OF CORONER		DATE		TIME		PLACE		CITY	
SIGNATURE OF JURY		DATE		TIME		PLACE		CITY	
SIGNATURE OF JUDGE		DATE		TIME		PLACE		CITY	
SIGNATURE OF CLERK		DATE		TIME		PLACE		CITY	
SIGNATURE OF SHERIFF		DATE		TIME		PLACE		CITY	
SIGNATURE OF DEPUTY SHERIFF		DATE		TIME		PLACE		CITY	
SIGNATURE OF CONSTABLE		DATE		TIME		PLACE		CITY	
SIGNATURE OF DEPUTY CONSTABLE		DATE		TIME		PLACE		CITY	
SIGNATURE OF JURY		DATE		TIME		PLACE		CITY	
SIGNATURE OF JUDGE		DATE		TIME		PLACE		CITY	
SIGNATURE OF CLERK		DATE		TIME		PLACE		CITY	
SIGNATURE OF SHERIFF		DATE		TIME		PLACE		CITY	
SIGNATURE OF DEPUTY SHERIFF		DATE		TIME		PLACE		CITY	
SIGNATURE OF CONSTABLE		DATE		TIME		PLACE		CITY	
SIGNATURE OF DEPUTY CONSTABLE		DATE		TIME		PLACE		CITY	

RECEIVED
JAN 22 1957
BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

258 CERTIFICATE OF DEATH

00245

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 615 Aldershot Rd		d. STREET ADDRESS 1 615 Aldershot Rd	
3. NAME OF DECEASED (Type or print) William F. Frenz Sr.		4. DATE OF DEATH Month Jan. Day 6 Year 1957	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 28, 1881
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 6 Days 19	IF UNDER 24 HRS. Hours 5 Min. 11
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Grocery	
11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Herman Frenz		14. MOTHER'S MAIDEN NAME Elizabeth Magleth	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-07-9197	
17. INFORMANT Mrs Ada Frenz		Address 615 Aldershot Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 6 hrs. 5 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cirrhosis of Liver			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan. 1-6, 1957 , to Jan 6, 1957 , that I last saw the deceased alive on Jan 6, 1957 , and that death occurred at 3:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE M.W. JACOBSON MD		ADDRESS (Street, city or town, state) 2310 Eutaw Place	
PHYSICIAN'S NAME (Type) M.W. JACOBSON MD		DATE SIGNED 1-8-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 9/57	22c. NAME OF CEMETERY OR CREMATORY Lorraine Park	22d. LOCATION (City, town, or county) (State) Woodlawn Md.
23. FLUNERAL DIRECTOR'S SIGNATURE Fanny H. Witzke		ADDRESS 4101 Edmondson Ave	
24a. REC'D BY REGISTRAR Jan 9 57		24b. REGISTRAR'S SIGNATURE W. Leach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

578 - CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]	
4. DATE OF DEATH [Faint text]		5. TIME OF DEATH [Faint text]		6. PLACE OF DEATH [Faint text]	
7. CAUSE OF DEATH [Faint text]		8. MANNER OF DEATH [Faint text]		9. SIGNATURE OF DECEASED [Faint text]	
10. SIGNATURE OF WITNESS [Faint text]		11. SIGNATURE OF PHYSICIAN [Faint text]		12. SIGNATURE OF CLERK [Faint text]	
13. SIGNATURE OF JUDGE [Faint text]		14. SIGNATURE OF SHERIFF [Faint text]		15. SIGNATURE OF CORONER [Faint text]	
16. SIGNATURE OF DISTRICT ATTORNEY [Faint text]		17. SIGNATURE OF COUNTY CLERK [Faint text]		18. SIGNATURE OF CITY CLERK [Faint text]	
19. SIGNATURE OF STATE CLERK [Faint text]		20. SIGNATURE OF DEPARTMENT CLERK [Faint text]		21. SIGNATURE OF RECORDS CLERK [Faint text]	
22. SIGNATURE OF HEALTH DEPARTMENT [Faint text]		23. SIGNATURE OF BALTIMORE CITY [Faint text]		24. SIGNATURE OF MARYLAND [Faint text]	

BUREAU V. S.

JAN 9 1957

RECEIVED

259

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 507 Windwood Rd.				d. STREET ADDRESS 507 Windwood Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First WILLIAM Middle C. Last FRITZ				4. DATE OF DEATH Month Jan. Day 29 , Year 1957			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 22, 1882	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Clerk				10b. KIND OF BUSINESS OR INDUSTRY Fraternal Order		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME William Fritz				14. MOTHER'S MAIDEN NAME Emilie Willms			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Lily W. Fritz - 507 Windwood Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from JUN 20, 1953 , to JAN 29, 1957 , that I last saw the deceased alive on JAN 29, 1957 , and that death occurred at 4 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6805 York Rd Baltimore 12 Md. DATE SIGNED 1/30/57							
ACTUAL SIGNATURE Laurence C. Post M.D.							
PHYSICIAN'S NAME (Type) LAURENCE C. POST							
22a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		22b. DATE THEREOF 2/1/57		22c. NAME OF CEMETERY OR CREMATORY Green Mount Cem. Maus/		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Vickers & Sons - Balto				ADDRESS 1744		24. REC'D BY REGISTRAR DATE 1 1957	
24b. REGISTRAR'S SIGNATURE Mabel Gray							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

CAUSE OF DEATH

PLACE OF BURIAL

DATE OF BURIAL

PLACE OF INTERMENT

AGE

SEX

CAUSE OF DEATH

SEX

CAUSE OF DEATH

PLACE OF BURIAL

CAUSE OF DEATH

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PLACE OF BURIAL

BUREAU V. S.

FEB 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00247

260

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calverton</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville 28</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ridgeway Manor, 5743 Edmondson Avenue</u>				e. STREET ADDRESS <u>06-2702</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>Winefred</u> Last <u>Fouke</u>				4. DATE OF DEATH Month <u>January</u> Day <u>30</u> Year <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 28, 1860</u>	
9. AGE (In years last birthday) <u>96</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Westminster Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John E. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Louise Capito</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Arthur Smith, 3605 Hillside Street</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular Occlusion</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>15 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Mar. 1953</u> , to <u>JAN 30, 1957</u> , that I last saw the deceased alive on <u>JAN. 23, 1957</u> , and that death occurred at <u>3:40 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Nelson McKay</u> M.D. <u>6014 Edmondson Ave Balte 28 Md.</u>				DATE SIGNED <u>1/31/57</u>			
PHYSICIAN'S NAME (Type) <u>J. Nelson McKay, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-1-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Westminster Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Westminster, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 31 57</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Smith</u>	

Sullivan et al.

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144

Figure 1

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The Journal of Law, Economics, & Organization, V16 N1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

261

CERTIFICATE OF DEATH

00248

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 470 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HAZEL Middle (NME) Last GARNETT				4. DATE OF DEATH Month January Day 10 Year 19 57			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 9, 1894	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager				10b. KIND OF BUSINESS OR INDUSTRY Pool Room		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Jennifer Garnett				14. MOTHER'S MAIDEN NAME Virginia Crump			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) THROMBOSIS, MIDDLE CEREBRAL ARTERY, LEFT DUE TO ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 7 MONTHS UNKNOWN						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 28, 1955 , to January 10, 1957 , and that death occurred at 3:10 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 1/10/57							
ACTUAL SIGNATURE Irving Freeman				M.D. VAH, FORT HOWARD, MARYLAND			
PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Chief, Medical Service VAH, Ft. Howard, Md							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Sept-13, 1957		22c. NAME OF CEMETERY OR CREMATORY Shiloh Cem		22d. LOCATION (City, town, or county) (State) Jamaica, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Katie Williams				ADDRESS 322 N. Schroeder St. Balto. Md		24a. REC'D BY REGISTRAR 14 1957	
24b. REGISTRAR'S SIGNATURE Dawson L. Fisher							

CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
DATE OF BIRTH [REDACTED]		PLACE OF BIRTH [REDACTED]		MARITAL STATUS [REDACTED]	
OCCUPATION [REDACTED]		CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]	
DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]	
SIGNATURE OF DECEASED [REDACTED]		SIGNATURE OF WITNESS [REDACTED]		SIGNATURE OF PHYSICIAN [REDACTED]	
SIGNATURE OF CLERK [REDACTED]		SIGNATURE OF REGISTRAR [REDACTED]		SIGNATURE OF JUDGE [REDACTED]	

BUREAU V. S.

JAN 14 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **00249**

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. LENGTH OF STAY IN 1b 2 YRS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 509 FAIRMOUNT AVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle SILBURN Last GARTON		4. DATE OF DEATH Month JAN Day 13 Year 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/24/87
9. AGE (in years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LINOTYPE		10b. KIND OF BUSINESS OR INDUSTRY NEWSPAPER	
11. BIRTHPLACE (State or foreign country) VA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME SPOTSWOOD F. GARTON		14. MOTHER'S MAIDEN NAME HOOVER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT WIFE - MRS STELLA		Address 509 FAIRMOUNT	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 10 YRS 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE William A. Pillsbury		DATE SIGNED 1/13/57	
EXAMINER'S NAME (Type) William A. Pillsbury		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 15, 1957	22c. NAME OF CEMETERY OR CREMATORY Jacksonville Reformed	22d. LOCATION (City, town, or county) (State) Jacksonville, Balto. Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland		24a. REC'D BY REGISTRAR JAN. 14, 1957	
		24b. REGISTRAR'S SIGNATURE Mabel C. Gray	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

JAN 16 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 FilmG209 1-10-57 et

263

CERTIFICATE OF DEATH

00250

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>---</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>6 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mercy Villa</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson Washington 6, D. C.</u> <u>47X-3</u>	
d. STREET ADDRESS <u>1026 - 16th St., N. W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>F.</u> Last <u>Gegan</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>3</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 30, 1870</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u>---</u> Days <u>---</u> Hours <u>---</u> Min. <u>---</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Scranton, Penna.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Gegan</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Morrissey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Miss Anne M. Mc Keever 2100 Conn Ave Wash 8 D. C.</u>	
17. INFORMANT <u>Address</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Anterior sclerotic cardio vascular disease</u> DUE TO (c) <u>---</u>	
INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>		10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>---</u> p. <u>---</u> 19 <u>---</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 27th</u> , 19 <u>56</u> , to <u>January 3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>January 3</u> , 19 <u>57</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>P.D. Flynn</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>11 East Chase Street #2</u> <u>1/4/57</u>	
PHYSICIAN'S NAME (Type) <u>Philip D. Flynn, M.D.</u>		<u>Baltimore 2, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 5, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H.W. Mearns Son 805 1/2 Calvert St.</u>		24a. REC'D BY REGISTRAR <u>JAN 7 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Mabel Gray</u>			

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

264

CERTIFICATE OF DEATH

Reg. Dist. No.

00251

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3yol-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CATON RIDGE NURSING HOME		d. STREET ADDRESS 1036 WILMOT COURT	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ANNA M. GEHRING		4. DATE OF DEATH Month Day Year JANUARY 26, 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 9, 1865
9. AGE (In years lost birthday) 91 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER AT HOME		10b. KIND OF BUSINESS OR INDUSTRY BALTIMORE MARYLAND.	
11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CHARLES C. GEHRING		14. MOTHER'S MAIDEN NAME KATHERINE DeBAUGH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Address MR. ARTHURE. PARKS 727 SPRINGFIELD AVE.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Myocarditis chronic with failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial hypertrophy DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 years 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Advancing years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No injury	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. none 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) no injury	
21. I certify that I attended the deceased from October 1956, to January 26, 1957, that I last saw the deceased alive on January 26, 1957, and that death occurred at 1:30 AM, from the causes and on the date stated above. dead ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE James Graham Marston M.D. 516 Cathedral Street Baltimore I-27-57 PHYSICIAN'S NAME (Type) James Graham Marston 516 Cathedral Street Baltimore Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/29/57	
22c. NAME OF CEMETERY OR CREMATORY ST. MARY'S CEMETERY		22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND.	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC BALTO. MD. Address 300 N. Charles St.		24a. REC'D BY REGISTRAR DATE JAN 31 57	
24b. REGISTRAR'S SIGNATURE Ouellet			

MAYLAND STATE DEPT. OF HEALTH-BALTIMORE, 18

BUREAU V. S.

JAN 31 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

265

CERTIFICATE OF DEATH

00252 44

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>340114</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. LENGTH OF STAY IN 1b <u>39 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HOWARD</u> Middle <u>P.</u> Last <u>GEORGE</u>		4. DATE OF DEATH Month <u>January</u> Day <u>9</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>November 4, 1897</u>
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u>59</u> Days <u>59</u> Hours <u>59</u> Min. <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber's Helper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plumbing Company</u>	
11. BIRTHPLACE (State or foreign country) <u>Summer Hill, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Jacob George</u>		14. MOTHER'S MAIDEN NAME <u>Esther Crum</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>030-07-6676</u>	
17. INFORMANT <u>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ENCEPHALOMALACIA</u> DUE TO <u>RECURRENT VASCULAR THROMBOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>MYOCARDIAL INFARCTION POSTERIOR WALL, LEFT VENTRICLE AT THE VERTEX</u> (c) <u>UNKNOWN</u>		INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>VA</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>December 1</u> , 19 <u>56</u> , to <u>January 9</u> , 19 <u>57</u> , and that death occurred at <u>2:25 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>VA HOSPITAL, FORT HOWARD, MARYLAND</u> DATE SIGNED <u>1/10/57</u>			
ACTUAL SIGNATURE <u>Rolando D. Ponce de Leon</u> M.D. <u>VA HOSPITAL, FORT HOWARD, MARYLAND</u>			
PHYSICIAN'S NAME (Type) <u>ROLANDO D. PONCE DE LEON, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-14-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Ce.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto, Md.</u>		24a. REC'D BY REGISTRAR <u>1/11/57</u>	
24b. REGISTRAR'S SIGNATURE <u>Dawson L. Gasky</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
Bridget		1890		Ireland	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE	
Married		1910		Ireland	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
1910		Baltimore, Md.		Dropsy of the heart	
AGE AT DEATH		SEX		COLOR	
20 years		Female		White	
DATE OF BURIAL		PLACE OF BURIAL		NAME OF FUNERAL HOME	
1910		Baltimore, Md.		St. Vincent's	
DATE OF INTERMENT		PLACE OF INTERMENT		NAME OF CEMETERY	
1910		Baltimore, Md.		St. Vincent's	
DATE OF REPORT		PLACE OF REPORT		NAME OF REPORTER	
1910		Baltimore, Md.		St. Vincent's	

BUREAU V. S.

JAN 14 1957

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

266

CERTIFICATE OF DEATH

00253

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3401-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 3810 Foster Avenue	
3. NAME OF DECEASED (Type or print) First Agatha Middle Bretzel Last Gephardt		4. DATE OF DEATH Month January Day 16 , Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 2, 1891
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Clement Bretzel		14. MOTHER'S MAIDEN NAME Cunigunda	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 446x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Senile arteriosclerotic nephrosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 17, 1956 , to Jan. 16, 1957 that I last saw the deceased alive on Jan. 16, 1957 , and that death occurred at 11:00a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 1-16-57			
ACTUAL SIGNATURE Stella Wachslar M.D.		PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 1-19-57		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY SACRED HEART CEM.		22d. LOCATION (City, town, or county) (State) 7226 EASTERN AVE BALTO. M.D.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Jelen		24a. REC'D BY REGISTRAR DATE 1/18/57	
ADDRESS 6044 Eastern Ave MD		24b. REGISTRAR'S SIGNATURE R. W. Hedrick	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
RICHARD J. ...		M		
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		CAUSE OF DEATH		MANNER OF DEATH	
...		
DATE OF INTERMENT		TIME OF INTERMENT		PLACE OF INTERMENT		CITY		STATE		COUNTRY		NAME OF FUNERAL HOME		NAME OF MINISTER	
...		
DATE OF REGISTRATION		TIME OF REGISTRATION		PLACE OF REGISTRATION		CITY		STATE		COUNTRY		NAME OF REGISTRAR		NAME OF CLERK	
...		

BUREAU V. 3

JAN 21 1957

RECEIVED

267

CERTIFICATE OF DEATH

0025444

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SPARROWS PT.		c. LENGTH OF STAY IN lb 65 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 911 D ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First AGNES Middle ROBINSON Last GILBERT		4. DATE OF DEATH Month 1 Day 17 Year 57	
5. SEX FEM.	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 21, 1879
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		9b. KIND OF BUSINESS OR INDUSTRY —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME (UNK)		14. MOTHER'S MAIDEN NAME KATE (UNK)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MORRIS L. GILBERT		Address SAME	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Arteriosclerotic Cardiovascular Disease DUE TO (c) Vascular Disease		INTERVAL BETWEEN ONSET AND DEATH 10 days 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. Month 19 Day 19 Year 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1955 , to Jan. 17, 1957 , that I last saw the deceased alive on Jan. 16, 1957 , and that death occurred at 12:45 P.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE David Owens		M.D. 914 D Street Balto. Md. 11/17/57	
PHYSICIAN'S NAME (Type) DR. DAVID OWENS			
22a. BURIAL, CREMATION, REINOVATION (Specify) BURIAL		22b. DATE THEREOF 1-19-57	
22c. NAME OF CEMETERY OR CREMATORY WESTERN		22d. LOCATION (City, town, or county) (State) BALTO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter R. Riddle, Dundalk, Md.		24a. REC'D BY REGISTRAR Jan 21 1957	
ADDRESS		24b. REGISTRAR'S SIGNATURE Lawson L. Fisher	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00255

268

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>123 Newberg Ave.</u>				d. STREET ADDRESS <u>123 Newberg Ave.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Eva</u> Middle <u>Kate</u> Last <u>Giles</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>9</u> Year <u>19 57</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 1, 1982</u>		9. AGE (In years last birthday) <u>74 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Evans</u>				14. MOTHER'S MAIDEN NAME <u>Hannah Moule</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT Address <u>Mrs. Ernest Harrington 123 Newberg Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>592x Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic hepatitis</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u> <u>1 year</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 23</u> , 19 <u>56</u> , to <u>Jan 9</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 9</u> , 19 <u>57</u> , and that death occurred at <u>7 A.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. G. Lally</u>				ADDRESS (Street, city or town, state) <u>3517 EDMONDSON AVE</u>			
PHYSICIAN'S NAME (Type) <u>LA. L. LALLY MD</u>				DATE SIGNED <u>3517 EDMONDSON AVE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-12-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Farley Ann. Home, Catonsville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 14 '57</u>		24b. REGISTRAR'S SIGNATURE <u>Overseer</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
MARRIAGE		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED	
OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION	
EDUCATION		EDUCATION		EDUCATION		EDUCATION		EDUCATION		EDUCATION		EDUCATION		EDUCATION	
RELIGION		RELIGION		RELIGION		RELIGION		RELIGION		RELIGION		RELIGION		RELIGION	
CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH	
DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH	
PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH	
CITY OF DEATH		CITY OF DEATH		CITY OF DEATH		CITY OF DEATH		CITY OF DEATH		CITY OF DEATH		CITY OF DEATH		CITY OF DEATH	
STATE OF DEATH		STATE OF DEATH		STATE OF DEATH		STATE OF DEATH		STATE OF DEATH		STATE OF DEATH		STATE OF DEATH		STATE OF DEATH	
COUNTRY OF DEATH		COUNTRY OF DEATH		COUNTRY OF DEATH		COUNTRY OF DEATH		COUNTRY OF DEATH		COUNTRY OF DEATH		COUNTRY OF DEATH		COUNTRY OF DEATH	
DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH	
PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH	
CITY OF DEATH		CITY OF DEATH		CITY OF DEATH		CITY OF DEATH		CITY OF DEATH		CITY OF DEATH		CITY OF DEATH		CITY OF DEATH	
STATE OF DEATH		STATE OF DEATH		STATE OF DEATH		STATE OF DEATH		STATE OF DEATH		STATE OF DEATH		STATE OF DEATH		STATE OF DEATH	
COUNTRY OF DEATH		COUNTRY OF DEATH		COUNTRY OF DEATH		COUNTRY OF DEATH		COUNTRY OF DEATH		COUNTRY OF DEATH		COUNTRY OF DEATH		COUNTRY OF DEATH	

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JAN 14 1957
BUREAU V. S.

269

CERTIFICATE OF DEATH

00256

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. LENGTH OF STAY IN 1b <u>35 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>		d. STREET ADDRESS <u>6501 Danville Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>THOMAS</u> Middle <u>L.</u> Last <u>GIVEN</u>		4. DATE OF DEATH Month <u>January</u> Day <u>7</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/29/89</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government Sheet metal work</u>	11. BIRTHPLACE (State or foreign country) <u>Tarentum, Pennsylvania</u>
13. FATHER'S NAME <u>Thomas D. Given</u>		14. MOTHER'S MAIDEN NAME <u>Isabelle Hardie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Clin. Rec., Vet. Adm. Hospital., Ft. Howard, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTS, ACUTE</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>RECENT</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____
20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>December 3, 1956</u> , to <u>January 7, 1957</u> , that on <u>January 7, 1957</u> , and that death occurred at <u>12:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Rolando Ponce de Leon</u> M.D. <u>VAH, FORT HOWARD, MARYLAND</u>		DATE SIGNED <u>1/7/57</u>	
PHYSICIAN'S NAME (Type) <u>ROLANDO D. PONCE DE LEON, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-11-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 9 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Dawson L. Farber</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. BIRTH DATE		6. BIRTH PLACE		7. MARRIAGE DATE		8. MARRIAGE PLACE		9. DECEASED DATE		10. DECEASED PLACE		11. DECEASED TIME		12. DECEASED TIME		13. DECEASED TIME		14. DECEASED TIME		15. DECEASED TIME		16. DECEASED TIME		17. DECEASED TIME		18. DECEASED TIME		19. DECEASED TIME		20. DECEASED TIME		21. DECEASED TIME		22. DECEASED TIME		23. DECEASED TIME		24. DECEASED TIME		25. DECEASED TIME		26. DECEASED TIME		27. DECEASED TIME		28. DECEASED TIME		29. DECEASED TIME		30. DECEASED TIME		31. DECEASED TIME		32. DECEASED TIME		33. DECEASED TIME		34. DECEASED TIME		35. DECEASED TIME		36. DECEASED TIME		37. DECEASED TIME		38. DECEASED TIME		39. DECEASED TIME		40. DECEASED TIME		41. DECEASED TIME		42. DECEASED TIME		43. DECEASED TIME		44. DECEASED TIME		45. DECEASED TIME		46. DECEASED TIME		47. DECEASED TIME		48. DECEASED TIME		49. DECEASED TIME		50. DECEASED TIME		51. DECEASED TIME		52. DECEASED TIME		53. DECEASED TIME		54. DECEASED TIME		55. DECEASED TIME		56. DECEASED TIME		57. DECEASED TIME		58. DECEASED TIME		59. DECEASED TIME		60. DECEASED TIME		61. DECEASED TIME		62. DECEASED TIME		63. DECEASED TIME		64. DECEASED TIME		65. DECEASED TIME		66. DECEASED TIME		67. DECEASED TIME		68. DECEASED TIME		69. DECEASED TIME		70. DECEASED TIME		71. DECEASED TIME		72. DECEASED TIME		73. DECEASED TIME		74. DECEASED TIME		75. DECEASED TIME		76. DECEASED TIME		77. DECEASED TIME		78. DECEASED TIME		79. DECEASED TIME		80. DECEASED TIME		81. DECEASED TIME		82. DECEASED TIME		83. DECEASED TIME		84. DECEASED TIME		85. DECEASED TIME		86. DECEASED TIME		87. DECEASED TIME		88. DECEASED TIME		89. DECEASED TIME		90. DECEASED TIME		91. DECEASED TIME		92. DECEASED TIME		93. DECEASED TIME		94. DECEASED TIME		95. DECEASED TIME		96. DECEASED TIME		97. DECEASED TIME		98. DECEASED TIME		99. DECEASED TIME		100. DECEASED TIME	
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BUREAU V. 2

JAN 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00257

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>Maryland</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	<u>3Y01.4</u>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in the Pines</u>	d. STREET ADDRESS <u>4920 Queensberry Ave</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rubin</u> Middle <u>Glassman</u> Last <u>Glassman</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>10</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1886</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shop</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Louis Glassman</u>		14. MOTHER'S MAIDEN NAME <u>Nettie?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Rebecca Glassman - 4920 Queensberry Ave</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction - Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>General arteriosclerosis - Chr. Coronary disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>Jan 10</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 9</u> , 19 <u>57</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Bernard Cohen</u> M.D. <u>The Maryland Apts</u> PHYSICIAN'S NAME (Type) <u>DR. BERNARD COHEN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Jan 11/57</u>	<u>Bnai Israel</u>	<u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Inc</u> ADDRESS <u>Solgerman 11202 - 1124-26W North Ave</u>		24a. REC'D BY REGISTRAR <u>JAN 14 57</u>	24b. REGISTRAR'S SIGNATURE <u>W. L. Smith</u>

BUREAU V. S.

JAN 14 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										00258				
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.				
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Franklintown					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Franklintown				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5306 Dogwood Road					e. STREET ADDRESS 5306 Dogwood Road					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First EDWARD Middle F. Last GOHR					4. DATE OF DEATH Month 1- Day 13 Year 1957									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 30, 1897		9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steam Fitter					10b. KIND OF BUSINESS OR INDUSTRY Md.					11. BIRTHPLACE (State or foreign country) Md.				
12. CITIZEN OF WHAT COUNTRY? 					13. FATHER'S NAME Edward F. Gohr					14. MOTHER'S MAIDEN NAME Ella A. Kidwell				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war dates of service) W.W.1					16. SOCIAL SECURITY NO. 214-03-5206					17. INFORMANT Lillian M. Gohr Address 5306 Dogwood Road				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis 002X DUE TO Broncho pneumonia Conditions, if any, which gave rise to immediate cause (b) Acute alcoholism (a), stating the underlying cause lost. DUE TO (c) 										INTERVAL BETWEEN ONSET AND DEATH 				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 322.0										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .														
ACTUAL SIGNATURE R. S. Fisher					M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED 1-13-57				
EXAMINER'S NAME (Type) R. S. FISHER					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>														
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 1-16-1957		22c. NAME OF CEMETERY OR CREMATORY Lorraine Park			22d. LOCATION (City, town, or county) (State) Woodlawn, Md.				
23. FUNERAL DIRECTOR'S SIGNATURE G. Howard Strong					ADDRESS 3707 W. North Ave.					24a. REC'D BY REGISTRAR 		24b. REGISTRAR'S SIGNATURE 		
										DATE JAN 15 57				

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
John J. Jones		Male		45		1/15/1912	
Place of Birth		Occupation		Cause of Death		Manner of Death	
Baltimore, Md.		Carpenter		Tuberculosis		Natural	
Residence		Date of Death		Time of Death		Place of Death	
1234 Main St.		1/15/57		10:00 AM		Home	
Physician		Medical Examiner		Signature		Signature	
J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith	

Med. Ex. causing as Tbc. (by phone 1/8/57)
 as.

RECEIVED
 JAN 15 1957
 BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00259

272

CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>McDonogh</u>				c. LENGTH OF STAY IN 1b <u>Lifetime</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2604 Military Ave. Pikesville, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>McDonogh School</u>				d. STREET ADDRESS <u>1604 Military Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>EDWARD</u> Last <u>Gorrie</u>				4. DATE OF DEATH Month <u>JAN</u> Day <u>10</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 9, 1883</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auditor-Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>McDonogh School</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Frank Gorrie</u>			
14. MOTHER'S MAIDEN NAME <u>Elva Booth</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>212-32-0432</u>				17. INFORMANT Address <u>Joseph H. Aten Box 275H Pasadena, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>few years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1952</u> to <u>10 JAN 1957</u> , that I last saw the deceased alive on <u>26 May 1956</u> , and that death occurred at <u>11 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>808 Reisterstown Rd. Pikesville, Md.</u> DATE SIGNED <u>10 Jan 57</u> ACTUAL SIGNATURE <u>Paul H Royce</u> M.D. <u>808 Reisterstown Rd. Pikesville, Md.</u> PHYSICIAN'S NAME (Type) <u>Paul H Royce M.D. Pikesville, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 12, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Howell, Pikesville</u> ADDRESS <u>Pikesville, Md.</u>				24a. REC'D BY REGISTRAR <u>Mary Eline</u> DATE <u>JAN 14 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Eline</u>	

BUREAU V. S.

JAN 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

273

CERTIFICATE OF DEATH

00260

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 1b <u>3 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>1525 W. Lanvale Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>HOWARD</u> Middle <u>F.</u> Last <u>GRIFFIN</u>				4. DATE OF DEATH Month <u>January</u> Day <u>16</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 20, 1924</u>	
9. AGE (In years last birthday) <u>32</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housing Authority</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Howard Griffin</u>				14. MOTHER'S MAIDEN NAME <u>Marian Phillips</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW II</u>				16. SOCIAL SECURITY NO. <u>212-20-4844</u>		17. INFORMANT <u>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MALIGNANT NEPHROSCLEROSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>446x</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>January 13, 1957</u> to <u>January 16, 1957</u> , and that death occurred at <u>12:50 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Veterans Administration Hospital</u> DATE SIGNED <u>1/16/57</u> ACTUAL SIGNATURE <u>Donald Mark</u> M.D. PHYSICIAN'S NAME (Type) <u>DONALD MARK, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-21-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marshall P. Hayes Funeral Home, 638 N. Gilmore St.</u> Baltimore, Maryland				24a. REC'D BY REGISTRAR <u>1/17/57</u>		24b. REGISTRAR'S SIGNATURE <u>Dawson L. Farberg</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 17 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

45

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Ba</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex-Middle River</u>		c. LENGTH OF STAY IN 1b <u>3 mos.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Martin Aircraft "C" Bldg Hosp.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex Middle River 20</u>	
3. NAME OF DECEASED (Type or print) <u>CANARY</u> First <u>Edmond</u> Middle <u>HALE</u> Last		4. DATE OF DEATH Month <u>1</u> Day <u>25</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OF RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-5-19</u>
9. AGE (In years last birthday) <u>37</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELECTRICIAN</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>AIRCRAFT</u>		11. BIRTHPLACE (State or foreign country) <u>Comer's Rock VA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>CANARY E. Hall</u>	
14. MOTHER'S MAIDEN NAME <u>Lura Stamper</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>1943-1946</u>	
16. SOCIAL SECURITY NO. <u>228-16-2460</u>		17. INFORMANT <u>Mr. Hubert Harmer</u> Address <u>54 Henderson Rd.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Electrocution (Accidental)</u> 914.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>5 Sec</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Grasped High Tension Wires</u>	
20c. TIME OF INJURY Hour <u>19</u> a. m. p. m.	20d. INJURY OCCURRED White <input checked="" type="checkbox"/> Not white <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Jack E. Collins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Jack E. Collins</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1-25-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/28/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Belair New Park</u>	22d. LOCATION (City, town, or county) (State) <u>Harford Co Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. Mahan Funeral Home</u>		ADDRESS <u>7401 Belair Rd.</u>	
24a. REC'D BY REGISTRAR <u>DATE JAN 28 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Edith Hurley</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		45		M		W		JAN 28 1957		BALTIMORE, MD	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		TITLE	
1234 E. BALTIMORE ST.		LABORER		HEART DISEASE		NATURAL		J. H. HARRIS		M.D.	
FAMILY PHYSICIAN		HISTORICAL DATA		PATHOLOGICAL DATA		TOPOGRAPHICAL DATA		LABORATORY DATA		OTHER DATA	
DR. J. H. HARRIS		BORN 1912		HEART DISEASE		BALTIMORE, MD		BALTIMORE, MD		BALTIMORE, MD	
1234 E. BALTIMORE ST.		LABORER		HEART DISEASE		NATURAL		J. H. HARRIS		M.D.	

RECEIVED
JAN 28 1957
BUREAU V. 1

1/28/57
J. H. HARRIS
BALTIMORE, MD

275

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville</u>				c. LENGTH OF STAY IN 1b <u>Lifetime</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>X1 Kingsville</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Roscoe</u> Last <u>Hammond</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>13</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 23, 1883</u>		9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dealer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Live Stock</u>		11. BIRTHPLACE (State or foreign country) <u>Kingsville Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joshua Hammond</u>				14. MOTHER'S MAIDEN NAME <u>Augusta Ledley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Jennie E. Hammond, Kingsville Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Rectum</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>8 mo. +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) <u>Kingsville, Md.</u>		(County) (State)	
21. I certify that I attended the deceased from <u>Nov. 1956</u> to <u>Jan. 13, 1957</u> , that I last saw the deceased alive on <u>Jan. 13, 1957</u> , and that death occurred at <u>10:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William A. Tyson</u> M.D.				ADDRESS (Street, city or town, state) <u>Kingsville, Md.</u>		DATE SIGNED <u>1-15-57</u>	
PHYSICIAN'S NAME (Type) <u>William A. Tyson</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 17, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Lutheran</u>		22d. LOCATION (City, town, or county) (State) <u>Joppa, Harford, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McComas & Son</u>				ADDRESS <u>Abingdon Md.</u>		24a. REC'D BY REGISTRAR DATE <u>1-14-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>WM Hammond</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 7 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00263

276

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 1b <u>22 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Veterans Administration Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS <u>2731 E. Monument Street</u>							
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>M.</u> Last <u>HAUSNER</u>				4. DATE OF DEATH Month <u>January</u> Day <u>17</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 13, 1883</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired Welder</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Steel Company</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>John Hausner</u>				14. MOTHER'S MAIDEN NAME <u>Mary MN: Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>OW</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>LOWER NEPHRON NEPHROSIS</u> IMMEDIATE CAUSE (a) <u>612X</u> DUE TO <u>TRANSURETHRAL RESECTION OF PROSTATE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>8 DAYS</u> <u>9 DAYS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>L. Pneumonitis right lower lobe. Plasma defects affecting coagulation (fibrinolytic enzyme)</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>VA</u> <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>December 26, 1956</u> , to <u>January 17, 1957</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above. <u>Joseph M. Miller</u> ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE M.D. <u>Veterans Administration Hospital</u> <u>1/17/57</u> PHYSICIAN'S NAME (Type) <u>JOSEPH M. MILLER, M.D., Chief, Surgical Service</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/21/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Schimunek Funeral Home, Inc.</u> <u>2601 E. Madison St.</u>				24a. REC'D BY REGISTRAR <u>DATE 21 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dawson L. Farley</u>	
Schimunek Funeral Home, 2601 E. Madison St., Baltimore, Md.							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00264

277

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 Middle River Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 213 Wampler Rd.				d. STREET ADDRESS 213 Wampler Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bertie G. Hensley				4. DATE OF DEATH Month Jan. Day 18 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 30, 1876		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months 18 Days 19 Hours 57 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Roanoke Co. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Hensley				14. MOTHER'S MAIDEN NAME Birch			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Leonard Hensley 213 Wampler Rd. 20			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thromboses 332x DUE TO Cerebral Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Sclerosis DUE TO Cerebral Sclerosis Generalized (c) Cerebral Sclerosis Generalized						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Plastic Embolism						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town)		(County) (State)		
21. I certify that I attended the deceased from Nov 30, 1956 , to Jan 18, 1957 , that I last saw the deceased alive on Jan 17, 1957 , and that death occurred at 1039 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Walter A. Anderson M.D.				DATE SIGNED Jan 13, 1957			
PHYSICIAN'S NAME (Type) Walter A. Anderson				3001 Shannon Drive Balto. 13, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF I-2I-57		22c. NAME OF CEMETERY OR CREMATORY Sherwood Cem.		22d. LOCATION (City, town, or county) (State) Roanoke Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Sassahn Tull Home 7401 Bodair Rd. Balto. Md.				24. REC'D BY REGISTRAR JAN 21 1957		24b. REGISTRAR'S SIGNATURE Edith Hurley	

RECEIVED

JAN 21 1957

BUREAU V. 1

MAYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18	
CERTIFICATE OF DEATH	
1. NAME OF DECEASED: Charles F. Hunter	
2. SEX: Male	
3. AGE: 30	
4. DATE OF BIRTH: Jan. 20, 1926	
5. PLACE OF BIRTH: Baltimore, Md.	
6. OCCUPATION: None	
7. CAUSE OF DEATH: Heart Disease	
8. PLACE OF DEATH: Baltimore, Md.	
9. DATE OF DEATH: Jan. 21, 1957	
10. SIGNATURE OF DECEASED: Charles F. Hunter	
11. SIGNATURE OF WITNESS: None	
12. SIGNATURE OF PHYSICIAN: None	
13. SIGNATURE OF CORONER: None	
14. SIGNATURE OF JURY: None	
15. SIGNATURE OF DEATH CERTIFICATE: None	
16. SIGNATURE OF DEATH CERTIFICATE: None	
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100. SIGNATURE OF DEATH CERTIFICATE: None	

Reg. Dist. No.

00265

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Pr. George's Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		c. LENGTH OF STAY IN lb 1 month, 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) S.E. Skyline, MD.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSP.		d. STREET ADDRESS 6005 REAMY DRIVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ERNST WALTER HICKMAN		4. DATE OF DEATH Month 1 Day 5 Year 1957			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/16/90	9. AGE (In years last birthday) yrs. 66	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST (RETIRED)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) GERMANY.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ? Unknown		14. MOTHER'S MAIDEN NAME Schubbelein	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT HERBERT HICKMAN Address 6005 REAMY DRIVE SKYLINE MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition and dehydration 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Psychosis with cerebral arteriosclerosis DUE TO (c) Generalized arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH weeks 1 year years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 12/3 , 19 56 , to 1/5 , 19 57 , that I last saw the deceased alive on 1/5 , 19 57 , and that death occurred at 3 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Spring Grove State Hospital DATE SIGNED 1/5/57 ACTUAL SIGNATURE Stella Wachslar M.D. Stella Wachslar PHYSICIAN'S NAME (Type) STELLA WACHSLER					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
Burial		Jan. 8, 1957		Odessa Hill Cem.	
22d. LOCATION (City, town, or county) (State)		Suitland Maryland.			
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
W.W. Chambers		DATE 1/9/57		W.W. Chambers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

may be retained by the hospital or attending physician.

DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

278

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 22		4. DATE OF BIRTH 1935	
5. PLACE OF BIRTH BALTIMORE, MARYLAND		6. OCCUPATION Student		7. MARITAL STATUS Single		8. EDUCATION High School	
9. PLACE OF DEATH BALTIMORE, MARYLAND		10. CAUSE OF DEATH Heart Disease		11. MANNER OF DEATH Natural		12. DATE OF DEATH 1957	
13. SIGNATURE OF DECEASED James H. Harris		14. SIGNATURE OF WITNESS John Doe		15. SIGNATURE OF PHYSICIAN Dr. Smith		16. SIGNATURE OF CORONER Mr. Jones	
17. SIGNATURE OF DECEASED James H. Harris		18. SIGNATURE OF WITNESS John Doe		19. SIGNATURE OF PHYSICIAN Dr. Smith		20. SIGNATURE OF CORONER Mr. Jones	
21. SIGNATURE OF DECEASED James H. Harris		22. SIGNATURE OF WITNESS John Doe		23. SIGNATURE OF PHYSICIAN Dr. Smith		24. SIGNATURE OF CORONER Mr. Jones	
25. SIGNATURE OF DECEASED James H. Harris		26. SIGNATURE OF WITNESS John Doe		27. SIGNATURE OF PHYSICIAN Dr. Smith		28. SIGNATURE OF CORONER Mr. Jones	
29. SIGNATURE OF DECEASED James H. Harris		30. SIGNATURE OF WITNESS John Doe		31. SIGNATURE OF PHYSICIAN Dr. Smith		32. SIGNATURE OF CORONER Mr. Jones	
33. SIGNATURE OF DECEASED James H. Harris		34. SIGNATURE OF WITNESS John Doe		35. SIGNATURE OF PHYSICIAN Dr. Smith		36. SIGNATURE OF CORONER Mr. Jones	
37. SIGNATURE OF DECEASED James H. Harris		38. SIGNATURE OF WITNESS John Doe		39. SIGNATURE OF PHYSICIAN Dr. Smith		40. SIGNATURE OF CORONER Mr. Jones	
41. SIGNATURE OF DECEASED James H. Harris		42. SIGNATURE OF WITNESS John Doe		43. SIGNATURE OF PHYSICIAN Dr. Smith		44. SIGNATURE OF CORONER Mr. Jones	
45. SIGNATURE OF DECEASED James H. Harris		46. SIGNATURE OF WITNESS John Doe		47. SIGNATURE OF PHYSICIAN Dr. Smith		48. SIGNATURE OF CORONER Mr. Jones	
49. SIGNATURE OF DECEASED James H. Harris		50. SIGNATURE OF WITNESS John Doe		51. SIGNATURE OF PHYSICIAN Dr. Smith		52. SIGNATURE OF CORONER Mr. Jones	
53. SIGNATURE OF DECEASED James H. Harris		54. SIGNATURE OF WITNESS John Doe		55. SIGNATURE OF PHYSICIAN Dr. Smith		56. SIGNATURE OF CORONER Mr. Jones	
57. SIGNATURE OF DECEASED James H. Harris		58. SIGNATURE OF WITNESS John Doe		59. SIGNATURE OF PHYSICIAN Dr. Smith		60. SIGNATURE OF CORONER Mr. Jones	
61. SIGNATURE OF DECEASED James H. Harris		62. SIGNATURE OF WITNESS John Doe		63. SIGNATURE OF PHYSICIAN Dr. Smith		64. SIGNATURE OF CORONER Mr. Jones	
65. SIGNATURE OF DECEASED James H. Harris		66. SIGNATURE OF WITNESS John Doe		67. SIGNATURE OF PHYSICIAN Dr. Smith		68. SIGNATURE OF CORONER Mr. Jones	
69. SIGNATURE OF DECEASED James H. Harris		70. SIGNATURE OF WITNESS John Doe		71. SIGNATURE OF PHYSICIAN Dr. Smith		72. SIGNATURE OF CORONER Mr. Jones	
73. SIGNATURE OF DECEASED James H. Harris		74. SIGNATURE OF WITNESS John Doe		75. SIGNATURE OF PHYSICIAN Dr. Smith		76. SIGNATURE OF CORONER Mr. Jones	
77. SIGNATURE OF DECEASED James H. Harris		78. SIGNATURE OF WITNESS John Doe		79. SIGNATURE OF PHYSICIAN Dr. Smith		80. SIGNATURE OF CORONER Mr. Jones	
81. SIGNATURE OF DECEASED James H. Harris		82. SIGNATURE OF WITNESS John Doe		83. SIGNATURE OF PHYSICIAN Dr. Smith		84. SIGNATURE OF CORONER Mr. Jones	
85. SIGNATURE OF DECEASED James H. Harris		86. SIGNATURE OF WITNESS John Doe		87. SIGNATURE OF PHYSICIAN Dr. Smith		88. SIGNATURE OF CORONER Mr. Jones	
89. SIGNATURE OF DECEASED James H. Harris		90. SIGNATURE OF WITNESS John Doe		91. SIGNATURE OF PHYSICIAN Dr. Smith		92. SIGNATURE OF CORONER Mr. Jones	
93. SIGNATURE OF DECEASED James H. Harris		94. SIGNATURE OF WITNESS John Doe		95. SIGNATURE OF PHYSICIAN Dr. Smith		96. SIGNATURE OF CORONER Mr. Jones	
97. SIGNATURE OF DECEASED James H. Harris		98. SIGNATURE OF WITNESS John Doe		99. SIGNATURE OF PHYSICIAN Dr. Smith		100. SIGNATURE OF CORONER Mr. Jones	

BUREAU V. S.

JAN 9 1957

RECEIVED

279

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) xo Ruxton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1003 Wagner Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NATHAN Middle B. Last HIGGINS		4. DATE OF DEATH Month Jan. 12, Day 19 Year 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 15, 1885
9. AGE (In years lost birthday) 71 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rtd. Pres.		10b. KIND OF BUSINESS OR INDUSTRY Power & Lighting	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Eleazer E. Higgins		14. MOTHER'S MAIDEN NAME Martha A. Lloyd	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212-07-2042A	
17. INFORMANT Mrs. Gertrude H. Higgins - 1003 Wagner Rd.		Address Ruxton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 154x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Carcinoma of Rectum DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Sudden 2 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 51 p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from January 1957 to January 1957 , that I last saw the deceased alive on deceased , 19 57 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2501 York Rd DATE SIGNED Charles F. O'Donnell M.D. ACTUAL SIGNATURE Charles F. O'Donnell M.D. PHYSICIAN'S NAME (Type) Towson #4 Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/15/57	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.	22d. LOCATION (City, town, or county) (State) Woodlawn, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Balto 17th		24a. REC'D BY REGISTRAR DATE 1/16/57	24b. REGISTRAR'S SIGNATURE Metel Gray

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 17 1957

RECEIVED

280

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>at home</u>			d. STREET ADDRESS <u>133 Maple Av (28)</u>		
3. NAME OF DECEASED (Type or print) <u>Harriet Teresa Hickey</u>			4. DATE OF DEATH <u>January 4 - 1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 15/1866</u>		9. AGE (In years last birthday) <u>90</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Geo. W. McClelland</u>			14. MOTHER'S MAIDEN NAME <u>M. Frances Dougherty</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	17. INFORMANT <u>Miss Isabella M. Hickey</u> Address <u>1810 E. Bond St.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular collapse</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General Arteriosclerosis</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>June</u> , 19 <u>41</u> , to <u>Jan 4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/4</u> , 19 <u>57</u> , and that death occurred at <u>6:15 PM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Harriet P. Lagia</u> M.D.			ADDRESS (Street, city or town, state) <u>326 Frederick St Baltimore Md</u>		
PHYSICIAN'S NAME (Type) <u>H. P. LAGIA</u>			DATE SIGNED _____		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Jan</u>		22b. DATE THEREOF _____	22c. NAME OF CEMETERY OR CREMATORY <u>Cathedral</u>		22d. LOCATION (City, town, or county) <u>Baltimore</u> (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>Steuertown</u> ADDRESS <u>Balto. Md</u>			24a. REC'D BY REGISTRAR <u>JAN 7 '57</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1957 2 Nov

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

281

CERTIFICATE OF DEATH

00268

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 BALTIMORE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>14 SPRING GROVE STATE HOSP.</u>		d. STREET ADDRESS <u>13 CENTRE PLACE DUNDALK</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>HISLEY</u> Last <u>HISLEY</u>		4. DATE OF DEATH Month <u>1</u> Day <u>1</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 9, 1899</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Not known</u>		14. MOTHER'S MAIDEN NAME <u>Not known</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>MISS THERESA HISLEY</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>DISEASE</u> DUE TO (c) <u>DISEASE</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ABCESS LEFT SHOULDER, FRACTURE PUBIS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-20</u> , 19 <u>57</u> , to <u>1-1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-1</u> , 19 <u>57</u> , and that death occurred at <u>10:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jerome E. Shapiro</u> M.D.		ADDRESS (Street, city or town, state) <u>4003 Hilton Rd. Balto</u> DATE SIGNED <u>1-1-57</u>	
PHYSICIAN'S NAME (Type) <u>Jerome E. Shapiro</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1/3/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MARYLAND.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HENRY SANDER & SONS INC</u> <u>BALTIMORE MARYLAND.</u>		24a. REC'D BY REGISTRAR <u>57</u> DATE <u>1-1-57</u>	
24b. REGISTRAR'S SIGNATURE <u>1-1-57</u>			

282

CERTIFICATE OF DEATH

00269

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Edmondale				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Edmondale			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5412 Addington Road				d. STREET ADDRESS 5412 Addington Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Robert Levin Hodson				4. DATE OF DEATH Month Jan. Day 9 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 19, 1869		9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Belmar Co.		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Eugene Hodson				14. MOTHER'S MAIDEN NAME Celeste Brommell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-07-9152		17. INFORMANT Address Mrs. Margaret L. Eidman 5412 Addington Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO CHENIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIO SCLEROTIC CARDIO-VASCULAR DISEASE - PULMONARY EDEMA - ANEURYSM (c) ANEURYSM							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/1 , 19 52 to 1/9 , 19 57 , that I last saw the deceased alive on 1/9 , 19 57 , and that death occurred at 7:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5801 Edmondale Ave. DATE SIGNED 1/9/57							
ACTUAL SIGNATURE John H. Shaw M.D.				PHYSICIAN'S NAME (Type) JOHN H. SHAW M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-12-1957		22c. NAME OF CEMETERY OR CREMATORY Greenmount		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard Strong				24a. REC'D BY REGISTRAR DATE JAN 11 1957		24b. REGISTRAR'S SIGNATURE A. J. Hedrick	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Form 100-1 (Rev. 1-25-60)

1. NAME (Last, first, middle initial)
2. DATE OF BIRTH (Month, day, year)
3. SEX (M, F)
4. RACE (White, Negro, American Indian, etc.)
5. HEIGHT (Feet, inches)
6. WEIGHT (Pounds)
7. EYES (Blue, Brown, Green, etc.)
8. HAIR (Black, Brown, Blond, etc.)
9. COMPLEXION (Fair, Ruddy, etc.)
10. BLOOD TYPE (A, B, AB, O)
11. SOCIAL SECURITY NUMBER
12. MARITAL STATUS (Single, Married, Divorced, etc.)
13. OCCUPATION
14. EDUCATION (Grade, College, etc.)
15. RELIGION
16. SIGNATURE
17. DATE

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JAN 11 1957
BUREAU V. 2

283

CERTIFICATE OF DEATH

Reg. Dist. No.

00270

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 70 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mercy Villa Nursing Home		d. STREET ADDRESS 4504 Hamilton Ave.	
3. NAME OF DECEASED (Type or print) First Frances J. Middle Hoerner Last		4. DATE OF DEATH Month Jan. Day 7, Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 18, 1867
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Howard Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Hausner		14. MOTHER'S MAIDEN NAME Mary Millbauer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Louis J. Reichart		Address 4504 Hamilton Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio-Vascular Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1957 to Jan 7 , 19 57 , that I last saw the deceased alive on Jan 7 , 19 57 , and that death occurred at 6 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE William G. Helfrich M.D.		ADDRESS (Street, city or town, state) 5006 Roland AB-Balto 10 DATE SIGNED 1/9/57	
PHYSICIAN'S NAME (Type) William G. Helfrich		5006 Roland Ave. Balto. 10, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 10, 1957	
22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home		ADDRESS 7401 Belair Rd	
24a. REC'D BY REGISTRAR Jan 10 1957		24b. REGISTRAR'S SIGNATURE Mabel Gray	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		RACE [REDACTED]	
DATE OF BIRTH [REDACTED]		PLACE OF BIRTH [REDACTED]		PLACE OF DEATH [REDACTED]	
OCCUPATION [REDACTED]		CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]	
TIME OF DEATH [REDACTED]		PLACE OF INTERMENT [REDACTED]		NAME OF FUNERAL HOME [REDACTED]	
SIGNATURE OF DECEASED [REDACTED]		SIGNATURE OF WITNESS [REDACTED]		SIGNATURE OF PHYSICIAN [REDACTED]	
DATE [REDACTED]		PLACE [REDACTED]		NAME [REDACTED]	

RECEIVED
 JAN 10 1957
 BUREAU V. 1

284
CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>812 Regester ave</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore 3401-4</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Armacost Nursing Home</i>		d. STREET ADDRESS <i>4309 Marble Hall Road</i>	
3. NAME OF DECEASED (Type or print) <i>VIOLET</i> First Middle Last <i>B HOFF</i>		4. DATE OF DEATH Month <i>Jan</i> Day <i>13</i> Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 23, 1864</i>
9. AGE (In years last birthday) <i>92</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Charles Worthington Hoff</i>		14. MOTHER'S MAIDEN NAME <i>Violet Hand Browne</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>no</i>	
17. INFORMANT <i>Mr. Charles W. Hoff, Falls Rd. Lutherville, Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Essential Hypertension, Cardiac</i> <i>443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive Impulsional Failure</i> DUE TO (c) <i>Cerebral hemorrhage, gangrene Rt. foot</i>		INTERVAL BETWEEN ONSET AND DEATH <i>30 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE. CONDITION GIVEN IN PART I (a) <i>Terminal pneumonia Bilateral</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1936</i> , 19____, to <i>Jan 12, 1957</i> , that I last saw the deceased alive on <i>Jan 12, 1957</i> , and that death occurred at <i>4:45 AM</i> , from the causes and on the date stated above. <i>JAN 13 1957</i> ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Ralph G. Hills</i> M.D.			
PHYSICIAN'S NAME (Type) <i>RALPH G. HILLS</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Jan 14, 1957</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Green Ridge Cemetery, Pikesville Balto Co. Md</i>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry W. Jenkins & Sons Co. York Road</i>		24a. REC'D BY REGISTRAR <i>DATE</i>	24b. REGISTRAR'S SIGNATURE <i>Mabel Gray</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18

6-2-5-10

<p>1. NAME OF DECEASED <i>John J. Smith</i></p>		<p>2. SEX <i>Male</i></p>		<p>3. AGE <i>45</i></p>	
<p>4. DATE OF DEATH <i>Jan 15 1957</i></p>		<p>5. TIME OF DEATH <i>10:30 AM</i></p>		<p>6. PLACE OF DEATH <i>Home</i></p>	
<p>7. CAUSE OF DEATH <i>Myocardial Infarction</i></p>		<p>8. MANNER OF DEATH <i>Natural</i></p>		<p>9. PLACE OF BIRTH <i>Boston, Mass.</i></p>	
<p>10. OCCUPATION <i>Engineer</i></p>		<p>11. MARITAL STATUS <i>Married</i></p>		<p>12. EDUCATION <i>High School</i></p>	
<p>13. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>14. SIGNATURE OF WITNESS <i>John J. Smith</i></p>		<p>15. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	
<p>16. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>17. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>18. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	
<p>19. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>20. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>21. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	
<p>22. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>23. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>24. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	
<p>25. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>26. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>27. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	
<p>28. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>29. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>30. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	
<p>31. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>32. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>33. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	
<p>34. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>35. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>36. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	
<p>37. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>38. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>39. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	
<p>40. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>41. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>42. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	
<p>43. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>44. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>45. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	
<p>46. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>47. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>48. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	
<p>49. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>50. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>51. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	
<p>52. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>53. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>54. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	
<p>55. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>56. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>57. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	
<p>58. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>59. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>60. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	
<p>61. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>62. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>63. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	
<p>64. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>65. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>66. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	
<p>67. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>68. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>69. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	
<p>70. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>71. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>72. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	
<p>73. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>74. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>75. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	
<p>76. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>77. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>78. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	
<p>79. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>80. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>81. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	
<p>82. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>83. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>84. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	
<p>85. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>86. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>87. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	
<p>88. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>89. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>90. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	
<p>91. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>92. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>93. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	
<p>94. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>95. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>96. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	
<p>97. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>98. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>99. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	
<p>100. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>101. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>102. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	

BUREAU Y. S.

JAN 16 1957

RECEIVED

285 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

COUNTY BALTO MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) _____
 OR _____
 TOWN CATONSVILLE
 HOSPITAL OR INSTITUTE OR STREET ADDRESS HOUSE IN THE PINES

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD COUNTY _____
 CITY (If outside corporate limits, write RURAL and give nearest town) _____
 OR _____
 TOWN BALTIMORE
 STREET ADDRESS (If rural give location) 843 W. 36th St.

3. NAME OF DECEASED:

(First) (Middle) (Last)
 (Type or Print) WILLIAM M. HOFFACKER

4. DATE OF DEATH: (Month) (Day) (Year)
JAN 12, 1957

5. SEX:

MALE

6. COLOR OR RACE:
WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: NOV 21, 1871

9. AGE last birthday: 85 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS.
 Months Days Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): INSPECTOR

10b. KIND OF BUSINESS OR INDUSTRY: BALTO. CITY

11. BIRTHPLACE (State or foreign country): MD

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

?

14. MOTHER'S MAIDEN NAME:

?

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) -

16. SOCIAL SECURITY No.: 217-26-6658

17. INFORMANT & ADDRESS:

Wm F. Hoffacker Sr. 6015 Sefton Ave.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

334X
 Immediate cause

(a)

DUE TO

Coronary vascular artery sclerosis

Interval Between Onset And Death

2 yrs

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

Arterio sclerosis Generalized

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Macrocytic Anemia

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct, 1956, to JAN 12, 1957, that I last saw the deceased

alive on JAN 10, 1957, and that death occurred at 6:50AM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

JAN 14 '57

W. L. Seaver

Paul E. Schmitt 365429 Chestnut Ave

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00273 38
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7816 Sheppard Avenue</u>				d. STREET ADDRESS <u>7816 Sheppard Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Mr. Fred</u> Middle <u>Rollin</u> Last <u>Hollis</u>				4. DATE OF DEATH Month <u>January</u> Day <u>16th</u> Year <u>19 57</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIAGE <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4, 1876</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Horticulturist</u>			10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Charles Hollis</u>			14. MOTHER'S MAIDEN NAME <u>?</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mrs. Kathryn L. Hollis, 7816 Sheppard</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u>		(County) <u> </u>	(State) <u> </u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>1/21/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gosport Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Gosport, Indiana</u>				(State) <u> </u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck 5305 Harford Road #14</u>				24a. REC'D BY REGISTRAR <u>JAN 18 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. L. M. Bacon</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

JAN 18 1957

RECEIVED

BUREAU V. S.

JAN. 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

288

CERTIFICATE OF DEATH

00275

33

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND <div style="text-align: center; font-size: 1.2em;">Baltimore</div>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY <div style="text-align: center; font-size: 1.2em;">Maryland. Baltimore</div>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div style="text-align: center; font-size: 1.2em;">Owings Mills</div>			c. LENGTH OF STAY IN 1b <div style="text-align: center; font-size: 1.2em;">19 years</div>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div style="text-align: center; font-size: 1.2em;">51 A. butus</div>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <div style="text-align: center; font-size: 1.2em;">Rosewood State Training School</div>				d. STREET ADDRESS <div style="text-align: center; font-size: 1.2em;">1200 Circle Drive</div>			
3. NAME OF DECEASED (Type or print) <div style="display: flex; justify-content: space-between;"> First Alma Middle Marie Last HOWSER </div>				4. DATE OF DEATH <div style="display: flex; justify-content: space-between;"> Month 1 Day 17 Year 19 57 </div>			
5. SEX <div style="text-align: center; font-size: 1.2em;">Female</div>		6. COLOR OR RACE <div style="text-align: center; font-size: 1.2em;">White</div>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <div style="text-align: center; font-size: 1.2em;">8/8/32</div>			9. AGE (In years last birthday) <div style="text-align: center; font-size: 1.2em;">24 yrs.</div>		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div style="text-align: center;">-----</div>			10b. KIND OF BUSINESS OR INDUSTRY <div style="text-align: center;">-----</div>		11. BIRTHPLACE (State or foreign country) <div style="text-align: center; font-size: 1.2em;">Baltimore, Md.</div>		
12. CITIZEN OF WHAT COUNTRY? <div style="text-align: center; font-size: 1.2em;">USA</div>			13. FATHER'S NAME <div style="text-align: center; font-size: 1.2em;">Edward Earl Howser</div>				
14. MOTHER'S MAIDEN NAME <div style="text-align: center; font-size: 1.2em;">ALMA MORRMAN</div>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <div style="text-align: center;">-----</div>				
16. SOCIAL SECURITY NO. <div style="text-align: center;">-----</div>			17. INFORMANT <div style="text-align: center; font-size: 1.2em;">Rosewood Records</div>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. Aspiration Pneumonia <div style="margin-left: 20px;">491X DUE TO</div> (b) 2. Congenital epilepsy <div style="margin-left: 20px;">Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</div> DUE TO (c) </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH <div style="font-size: 1.2em;">3 days</div> <div style="font-size: 1.2em;">since birth</div> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <div style="text-align: center;">-----</div>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1/14/57 , 19____, to 1/17/57 , 19____, that I last saw the deceased alive on 1/17/57 , 19____, and that death occurred at 11:00 A. from the causes and on the date stated above. <div style="display: flex; justify-content: space-between;"> Ernest I. Decko, M.D. Owings Mills, Md. ADDRESS (Street, city or town, state) DATE SIGNED </div>							
ACTUAL SIGNATURE Richard Lindenberg (Physician) M.D.							
PHYSICIAN'S NAME (Type) Richard Lindenberg, M.D. 700 E. Fleet Fleet St., Balt., Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <div style="text-align: center; font-size: 1.2em;">Burial</div>		22b. DATE THEREOF <div style="text-align: center; font-size: 1.2em;">1-21-57</div>		22c. NAME OF CEMETERY OR CREMATORY <div style="text-align: center; font-size: 1.2em;">Holy Cross Cemetery</div>			
22d. LOCATION (City, town, or county) (State) <div style="text-align: center; font-size: 1.2em;">Baltimore, Maryland</div>		23. FUNERAL DIRECTOR'S SIGNATURE <div style="text-align: center; font-size: 1.2em;">Howard H. Hubbard 4107 Wilkens Avenue</div>					
24a. REC'D BY REGISTRAR <div style="text-align: center; font-size: 1.2em;">DATE 21 1957</div>		24b. REGISTRAR'S SIGNATURE <div style="text-align: center; font-size: 1.2em;">Mary Eline</div>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		MALE		30		JAN 15 1927	
PLACE OF BIRTH		CITY		STATE		COUNTRY	
BALTIMORE		MD		USA		USA	
OCCUPATION		EDUCATION		RELIGION		MARRIAGE	
LABORER		HIGH SCHOOL		METHODIST		MARRIED	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
JAN 21 1957		BALTIMORE		HEART DISEASE		NATURAL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE		PLACE		CITY		STATE	
JAN 21 1957		BALTIMORE		MD		USA	

BUREAU V. S.

JAN 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page J should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

289

CERTIFICATE OF DEATH

Reg. Dist. No. 00276

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 3 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House In The Pines 16 Rusting Ave				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Edwin Roys Humphrey				4. DATE OF DEATH Jan. 13, 1957			
5. SEX M.		6. COLOR OR RACE W.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 16, 1874	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Ins. & Real Estate O.B.				10b. KIND OF BUSINESS OR INDUSTRY Mass.			
11. BIRTHPLACE (State or foreign country) USA				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME E.D. Humphrey				14. MOTHER'S MAIDEN NAME Martha Beckwith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs John LaVeck, 25 Holmehurst Ave				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO with cerebral degeneration Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Feb 8 , 19 54 , to Jan 13 , 19 57 , that I last saw the deceased alive on Jan 12 , 19 57 , and that death occurred at 1:15 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1118 St Paul St Baltimore 2 Md DATE SIGNED							
ACTUAL SIGNATURE John A. Nesbitt Jr. M.D.							
PHYSICIAN'S NAME (Type) JOHN A. NESBITT JR.				Baltimore 2 Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal				22b. DATE THEREOF Jan. 14/57			
22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or county) (State) Great Barrington Mass.			
23. FUNERAL DIRECTOR'S SIGNATURE Harry A. Witke				ADDRESS 4101 Edmondson Ave			
24a. REC'D BY REGISTRAR Jan 15 57				24b. REGISTRAR'S SIGNATURE Robert Smith			

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18

BUREAU V. B.

JAN 16 1957

RECEIVED

207

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HALETHORPE		c. LENGTH OF STAY IN 1b 12 YRS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4607 RIDGE AVE.		d. STREET ADDRESS 4607 RIDGE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES WILLIAM ISAAC		4. DATE OF DEATH Month Day Year JAN 14 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 23 1902
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER		10b. KIND OF BUSINESS OR INDUSTRY BLDG. SUPPLIES	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME AUGUSTUS ISAAC		14. MOTHER'S MAIDEN NAME BESSIE RINEHART	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 218-12-4023	
17. INFORMANT MRS. CLOROM ISAAC		Address BALTO-27MD. 4607 RIDGE AVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sarcoma left kidney 180X DUE TO Secondary metastases - Liver - 5 Keel. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) He had been - Leukemia (c) 100% C			INTERVAL BETWEEN ONSET AND DEATH 7.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct 1956 to Jan 14 1957 , that I last saw the deceased alive on Jan 12 1957 , and that death occurred at 6:30 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Frederic V. Beiler		ADDRESS (Street, city or town, state) M.D. 1014 Francis Ave - Balto 27 - Md	
PHYSICIAN'S NAME (Type) FREDERIC V. BEILER		DATE SIGNED Jan 14 57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1/17/1957	22c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE MEM	22d. LOCATION (City, town, or county) (State) WASH. BLVD & DORSEY RD
23. BURIAL DIRECTOR'S SIGNATURE Easton Son		ADDRESS CATONSVILLE, Md.	
24a. REC'D BY REGISTRAR Jan 15 57		24b. REGISTRAR'S SIGNATURE See Keyfile	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

1

290

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00278

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Wilson State Hospital</u>				d. STREET ADDRESS <u>13X22</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>THOMAS</u> Middle <u>OLIVER</u> Last <u>JOHNSON</u>				4. DATE OF DEATH Month <u>January</u> Day <u>3</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-12-08</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>meat cutter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Meat business</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>ALGERNON JOHNSON</u>				14. MOTHER'S MAIDEN NAME <u>MARY E. GRIMSLEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-27-8681</u>		17. INFORMANT Address <u>Hospital records, Mt. Wilson State Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Tuberculosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>002 X</u> DUE TO (c) <u>4 years</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-18</u> , 19 <u>56</u> , to <u>1-3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-3</u> , 19 <u>57</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>William Newcomer</u> M.D.				DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>William Newcomer, M.D. Supt.</u>				Mt. Wilson, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>JAN 6/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dunwoody Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Howard Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Roy W. Barber</u> ADDRESS <u>Daytonville Md</u>				24a. REC'D BY REGISTRAR <u>JAN 9 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Sorothy Newells</u>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

BUREAU V. 3.

1957 6 JAN

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED (Type or Print) Walter R. Johnson			2. DATE OF DEATH 1/5/57		
3. PLACE OF DEATH: A. Baltimore City B. Full Name of (If not in hospital or institution, give street address or location) 5228 Old Frederick Rd.			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY Balt		
C. CITY OR TOWN Baltimore			D. STREET ADDRESS (If rural, give location) 5228 Old Frederick Rd.		
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 7/31/85	9. AGE (In years last birthday) 71	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Wm T. Johnson			14. MOTHER'S MAIDEN NAME Ida Wells		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		
17. INFORMANT Catherine A. Johnson (Wife)			ADDRESS Same		

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 4221	CAUSE OF DEATH (A) Congestive Failure DUE TO (B) Arterio-Sclerotic C-V. Dis DUE TO (C)	INTERVAL BETWEEN ONSET AND DEATH 2 yrs ?
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 260x		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes		

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	

22. I certify that (I) (this hospital) attended the deceased from **10-10-** **1956** to **1/5** **1957**, that (I) ~~(we)~~ last saw the deceased alive on **1/5** **1957**, and that death occurred at **12:45 Pm.**, from the causes and on the date stated above.

23A. SIGNATURE Walter R. Johnson ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	23B. ADDRESS Catonsville, Md.	23C. DATE SIGNED 1/7/57
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24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 1/9/57	24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	24D. LOCATION (City, town, or county) (State) Balto., Md.
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DATE RECEIVED BY Jan 9, 1957	REGISTRAR'S SIGNATURE W. H. [Signature]	25. FUNERAL DIRECTOR McCalla Funeral Home	ADDRESS 130 E. Fort Ave.
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THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and let HIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

MEL CERTIFICATION

BUREAU V. A.

JAN 11 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00280

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 22 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 307 Oak Forest Avenue				d. STREET ADDRESS 307 Oak Forest Avenue			
3. NAME OF DECEASED (Type or print) First MIRIAM Middle C. Last JONES				4. DATE OF DEATH Month January Day 29 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 19, 1908.		9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Enoch Hill Crosby				14. MOTHER'S MAIDEN NAME Ida P. Rhodes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT C. Kenneth Jones		Address 307 Oak Forest Ave. Catonsville 28, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Barbiturate Intoxication 970.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Overdose of Barbiturate					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 1/29 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Catonsville Baltimore Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>William V. Lovitt</i> EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1/30/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation		22b. DATE THEREOF Feb. 1, 1957		22c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		22d. LOCATION (City, town, or county) (State) Chicopee Falls, Hamden Co. Mass.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Coston Sons, Catonsville 28, Md.</i>				ADDRESS		24a. REC'D BY REGISTRAR DATE FEB 4 '57	
						24. REGISTRAR'S SIGNATURE <i>W. H. Leach</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the office of the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, and cause of death. The form is mostly blank with some faint markings.

BUREAU A. 1

FEB 4 1957

RECEIVED

293 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 2 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 3401-4 713 S. Bond Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARION Middle J. Last KACZYNSKI				4. DATE OF DEATH Month January Day 5 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/30/07		9. AGE (In years last birthday) 49 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Construction Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Kaczynski				14. MOTHER'S MAIDEN NAME Constance MN: Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW-II		16. SOCIAL SECURITY NO. 218-14-9336		17. INFORMANT Address Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CIRRHOSIS OF LIVER 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 3, 1957 , to January 5, 1957 , that I last saw the deceased alive on January 5, 1957 , and that death occurred at 2:55 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, Fort Howard, Maryland DATE SIGNED 1/6/57 ACTUAL SIGNATURE Rolando Ponce de Leon M.D. VAH, Fort Howard, Maryland PHYSICIAN'S NAME (Type) ROLANDO PONCE DE LEON, M.D. VAH, Fort Howard, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/9/57		22c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William S. Fialkowski				24a. REC'D BY REGISTRAR JAN 8 1957		24b. REGISTRAR'S SIGNATURE Dawson L. Farley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

291

CERTIFICATE OF DEATH

002823

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Maryland</u>				c. LENGTH OF STAY IN 1b <u>10 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. d. STREET ADDRESS <u>Valley Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ralph</u> Middle <u>Frederick</u> Last <u>Kelbaugh</u>				4. DATE OF DEATH Month <u>January</u> Day <u>28</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/28/37</u>	9. AGE (In years last birthday) <u>19</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ralph Marr Kelbaugh</u>				14. MOTHER'S MAIDEN NAME <u>Audrey Virginia Damast</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. -----		17. INFORMANT <u>Rosewood Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis of left jugular vein and sinus</u> <u>471X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>due to acute abscess of sphenoid sinus.</u> DUE TO (c) <u>Aspiration bronchopneumonia.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Birth injury of brain.</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>January 18, 19 57</u> , to <u>January 28, 19 57</u> , that I last saw the deceased alive on <u>January 28, 19 57</u> , and that death occurred at <u>10:40 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>1/29/57</u>							
ACTUAL SIGNATURE <u>Ellis S. Margolin</u> M.D.				DATE SIGNED <u>1/29/57</u>			
PHYSICIAN'S NAME (Type) <u>Ellis Margolin, Pathologist</u> <u>Springfield St. Hosp., Sykesville, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-4-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>David Ridge Cem.</u>		22d. LOCATION (City, town, or county) <u>Pikeville</u>		(State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Garley Sunval Home-Catonsville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 6 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Elie</u>	

RECEIVED

295

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 1 Day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH Month January Day 26 Year 1957				5. DATE OF DEATH Month January Day 26 Year 1957			
3. NAME OF DECEASED (Type or print) ROBERT C. KIBLER		First Middle Last		4. DATE OF DEATH Month January Day 26 Year 1957		5. DATE OF DEATH Month January Day 26 Year 1957	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/2/14	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction Co.		11. BIRTHPLACE (State or foreign country) Luray, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Oscar M. Kibler				14. MOTHER'S MAIDEN NAME Mary Martin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-II 579 01 3685		17. INFORMANT Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) IDIOPATHIC PURPURA 296x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that XVA attended the deceased from January 25, 1957 , to January 26, 1957 , that I last saw the deceased 8:50 P.M. and that death occurred at 8:50 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Donald D. Mark		ADDRESS (Street, city or town, state) VAH, Fort Howard, Maryland				DATE SIGNED 1/28/57	
PHYSICIAN'S NAME (Type) DONALD D. MARK, M.D.		VAH, Fort Howard, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-29-57		22c. NAME OF CEMETERY OR CREMATORY North East Methodist Cemetery		22d. LOCATION (City, town, or county) (State) North East, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight Inc.		ADDRESS 6009 Harford Rd. Balto. Md.		24a. REC'D BY REGISTRAR DATE 1-30-57		24b. REGISTRAR'S SIGNATURE Dawson L. Farley	

Shipped to: Joseph Grant Funeral Home, North East, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1957

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

296

CERTIFICATE OF DEATH

00284

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Balt.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. LENGTH OF STAY IN 1b <u>7 hrs. 37 Min.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>7717 E. Dale Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle <u>L.</u> Last <u>KINDER</u>				4. DATE OF DEATH Month <u>January</u> Day <u>5</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/30/94</u>	
9. AGE (In years lost birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Modern Linotypes</u>		11. BIRTHPLACE (State or foreign country) <u>Lacrosse, Wisconsin</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Eric H. Kinder</u>				14. MOTHER'S MAIDEN NAME <u>Olga Freise</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW-I</u>				16. SOCIAL SECURITY NO. <u>577 05 8110</u>		17. INFORMANT <u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF LUNG WITH MULTIPLE METASTASES</u> DUE TO <u>163X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>57</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January 5, 19 57</u> , to <u>January 5, 19 57</u> , that I last saw the deceased alive on <u>January 5, 19 57</u> , and that death occurred at <u>6:12 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>VAH, Fort Howard, Md.</u> DATE SIGNED <u>1/6/57</u> ACTUAL SIGNATURE <u>Rolando P. Ponce de Leon</u> M.D. PHYSICIAN'S NAME (Type) <u>ROLANDO PONCE DE LEON, M.D.</u> <u>VAH, Fort Howard, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-9-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Im. Cook-Blight, Inc.</u> ADDRESS <u>6009 Harford Rd. Balto. Md.</u>				24a. REC'D BY REGISTRAR <u>1/10/57</u>		24b. REGISTRAR'S SIGNATURE <u>Dawson L. Larber</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE	
DATE OF DEATH		PLACE OF DEATH		CITY	
HUSBAND		WIFE		CHILD	
FATHER		MOTHER		SISTER	
BROTHER		Nephew		Uncle	
Cause of Death		Immediate Cause		Underlying Cause	
Manner of Death		Occupation		Education	
Date of Birth		Date of Death		Date of Burial	
Signature of Physician		Signature of Registrar		Signature of Coroner	
Signature of Medical Examiner		Signature of Pathologist		Signature of Anatomist	
Signature of Surgeon		Signature of Dentist		Signature of Pharmacist	
Signature of Nurse		Signature of Midwife		Signature of Priest	
Signature of Minister		Signature of Rabbi		Signature of Imam	
Signature of Other		Signature of Other		Signature of Other	

BUREAU V. S.

JAN 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

208 CERTIFICATE OF DEATH

Reg. Dist. No.

00285

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4205 Wilkens Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Vernon M. Kinker</u>				4. DATE OF DEATH Month Day Year <u>Jan. 6 1957</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 5, 1891</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician, Riggs Distler Co.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Christopher M. Kinker</u>				14. MOTHER'S MAIDEN NAME <u>Christine Arentz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs Jennie Kinker, 4205 Wilkens Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung & Generalized Carcinomatosis</u> <u>163x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/1</u> , 19 <u>55</u> , to <u>1/6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/5/57</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John C. Healy</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Baltimore, Md 1/7/57</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 9/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Louden Park</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. Wittle</u>				ADDRESS <u>4101 Edmondson Ave</u>		24b. REGISTRY BY REGISTRAR DATE <u>JAN 9 1957</u>	
				24c. REGISTRAR'S SIGNATURE <u>Dr. Geo. M. Kieffer</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

THE DEATH OF

NAME OF DECEASED	DATE OF BIRTH	PLACE OF BIRTH
SEX	DATE OF DEATH	PLACE OF DEATH
EDUCATION	CAUSE OF DEATH	DIAGNOSIS
RELIGION	DATE OF BURIAL	PLACE OF BURIAL

DATE OF DEATH	PLACE OF DEATH	CAUSE OF DEATH
DATE OF BURIAL	PLACE OF BURIAL	DIAGNOSIS
DATE OF INTERMENT	PLACE OF INTERMENT	DIAGNOSIS
DATE OF CREMATION	PLACE OF CREMATION	DIAGNOSIS

DATE OF DEATH	PLACE OF DEATH	CAUSE OF DEATH
DATE OF BURIAL	PLACE OF BURIAL	DIAGNOSIS
DATE OF INTERMENT	PLACE OF INTERMENT	DIAGNOSIS
DATE OF CREMATION	PLACE OF CREMATION	DIAGNOSIS

DATE OF DEATH	PLACE OF DEATH	CAUSE OF DEATH
DATE OF BURIAL	PLACE OF BURIAL	DIAGNOSIS
DATE OF INTERMENT	PLACE OF INTERMENT	DIAGNOSIS
DATE OF CREMATION	PLACE OF CREMATION	DIAGNOSIS

DATE OF DEATH	PLACE OF DEATH	CAUSE OF DEATH
DATE OF BURIAL	PLACE OF BURIAL	DIAGNOSIS
DATE OF INTERMENT	PLACE OF INTERMENT	DIAGNOSIS
DATE OF CREMATION	PLACE OF CREMATION	DIAGNOSIS

DATE OF DEATH	PLACE OF DEATH	CAUSE OF DEATH
DATE OF BURIAL	PLACE OF BURIAL	DIAGNOSIS
DATE OF INTERMENT	PLACE OF INTERMENT	DIAGNOSIS
DATE OF CREMATION	PLACE OF CREMATION	DIAGNOSIS

DATE OF DEATH	PLACE OF DEATH	CAUSE OF DEATH
DATE OF BURIAL	PLACE OF BURIAL	DIAGNOSIS
DATE OF INTERMENT	PLACE OF INTERMENT	DIAGNOSIS
DATE OF CREMATION	PLACE OF CREMATION	DIAGNOSIS

BUREAU V. S.

1 JAN 9 1957

RECEIVED

RECEIVED

297

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) English Consul				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) English Consul (Balto Zone 27)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4431 Walnut Road				e. STREET ADDRESS 4431 Walnut Road			
3. NAME OF DECEASED (Type or print) First JOHN Middle WILLIAM Last KLEBE				4. DATE OF DEATH Month Sat. Day Jan. Year 26, 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 28, 1880	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Shop Helper		10b. KIND OF BUSINESS OR INDUSTRY Shipyard Mach. Sh. Repairing		11. BIRTHPLACE (State or foreign country) Baltimore City, Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Henry Klebe				14. MOTHER'S MAIDEN NAME Mary (?)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Mrs. Mary B. Klebe (Wife), Address Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage. 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis (c) 5 years						INTERVAL BETWEEN ONSET AND DEATH 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Dec 15 , 19 56 to Jan 26 , 19 57 , that I last saw the deceased alive on Jan 26 , 19 57 , and that death occurred at 2:45 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2301 Annapolis Rd DATE SIGNED Dr. Geo. M. Kieffer							
ACTUAL SIGNATURE Paul Schufeldt M.D.							
PHYSICIAN'S NAME (Type) Paul Schufeldt							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 29 57		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Baltimore City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE A. HOWARD EVANS				ADDRESS 1400 S. Charles St. Balto 30 Md		24a. REC'D BY REGISTRAR DATE 1-28-57	
				24b. REGISTRAR'S SIGNATURE Dr. Geo. M. Kieffer			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

JAN 29 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00287

298

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X 2 Baltimore (12)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Towson Nursing Home</u>		d. STREET ADDRESS <u>1 606 Hatherleigh Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Arnold</u> Middle <u>J.</u> Last <u>Kleff</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>12</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 29, 1877</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Sec'y Martha Washington</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Candy Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Arnold J. Kleff</u>		14. MOTHER'S MAIDEN NAME <u>Gertrude Voshell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mr. Arnold J. Kleff, Jr</u>		Address <u>1407 W. Chesapeake Ave</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Lymphatic Leukemia</u> 204.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>June 10, 1953</u> to <u>Jan 12, 1957</u> , that I last saw the deceased alive on <u>Jan 12</u> , 19 <u>57</u> , and that death occurred at <u>9 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u> </u>			
ACTUAL SIGNATURE <u>Laurence C. Post</u> M.D.			
PHYSICIAN'S NAME (Type) <u>LAURENCE C. Post M.D. 6505 York Rd - W. Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		22b. DATE THEREOF <u>1/15/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. W. Measor, Son</u>		ADDRESS <u>8057 Calvert St</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Mabel Gray</u>	

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BUREAU OF THE ARMY

BUREAU V. S.

JAN 16 1957

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00288

CERTIFICATE OF DEATH

Reg. Dist. No. 33

299

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Reisterstown</u>		LENGTH OF STAY (in this place) <u>40 yrs</u>		TOWN <u>Reisterstown</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cherry Hill Road</u>		STREET ADDRESS <u>Cherry Hill Road</u>					
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Anna Louise Korman</u>				<u>Jan 10 19 57</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>Apr 20 1898</u>	9. AGE last birthday <u>58</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
						Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Wm Brothers</u>				14. MOTHER'S MAIDEN NAME <u>Ida May Beaver</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Geo W Korman Reisterstown Md</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>September 16, 1956</u> , to <u>January 10, 1957</u> , that I last saw the deceased alive on <u>Jan 3, 1957</u> , and that death occurred at <u>8:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Clarence E. McWilliams</u> M.D. <u>Reisterstown</u>				DATE SIGNED <u>January 11, 1957</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan 13 1957</u>		NAME OF CEMETERY OR CREMATORY <u>All Saints Cemetery</u>		LOCATION (City, town, or county) (State) <u>Reisterstown Md</u>	
24. REC'D BY REGISTRAR <u>1-10-57</u>		REGISTRAR'S SIGNATURE <u>Mary B. Zee</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Berryman</u>		ADDRESS <u>Reisterstown</u>	

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00289 30

Reg. Dist. No.

300

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY a.a. ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 6mth9days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Michael Middle Kortz Last Kortz		4. DATE OF DEATH Month January Day 29 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 24, 1887
9. AGE (In years last birthday) 69 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired roofer	11. BIRTHPLACE (State or foreign country) Yugoslavia
12. CITIZEN OF WHAT COUNTRY? Yugoslavia ✓		13. FATHER'S NAME unknown	
14. MOTHER'S MAIDEN NAME unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular accident 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio-sclerotic cardio-vascular DUE TO (c) disease			INTERVAL BETWEEN ONSET AND DEATH 20 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 19, 19 56 to Jan. 29, 19 57 , that I last saw the deceased alive on Jan 29, 19 57 , and that death occurred at 4:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 1-29-57			
ACTUAL SIGNATURE Jerome E. Shapiro M.D.		PHYSICIAN'S NAME (Type) Jerome E. Shapiro, M. D. Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/1/57	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.	22d. LOCATION (City, town, or county), (State) 2930 Frederick Ave
23. FUNERAL DIRECTOR'S SIGNATURE John G. Cowan		24a. REC'D BY REGISTRAR DATE 1-29-57	24b. REGISTRAR'S SIGNATURE A. J. Hedrick

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00290

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u> ✓	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonsville</u>		LENGTH OF STAY (in this place) <u>2 wks</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Balto.</u>		<u>3701.4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ridgeway Manor Home</u>				STREET ADDRESS (If rural give location) <u>4702 Delaware Ave</u>			
3. NAME OF DECEASED (Type or Print) <u>Selma</u> (First) <u>Kreis</u> (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 6,</u> <u>1957</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M.</u>	8. DATE OF BIRTH <u>7-22-1876</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Warrenton, N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>William Williams</u>				14. MOTHER'S MAIDEN NAME <u>Georgia Sledge</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mr. Wm O'Nora 727 6th St. Baltimore</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A) <u>Thrombosis, Cerebral</u>				INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Cardiovascular Disease</u>				<u>5 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Osteoarthritis generalized severe</u>				<u>15 years</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-21</u> , 19 <u>56</u> , to <u>Jan. 6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan. 6</u> , 19 <u>57</u> , and that death occurred at <u>2:20 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>John F. Schaefer</u>				ADDRESS (Street, city, town, state) DATE SIGNED <u>401 Randon Road - Balto. Md. 1/8/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-9-57</u>		NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>		LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Deborah</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Loring Byers</u>		ADDRESS <u>5005 Pk. Hyattsville Balto 15, Md.</u>	
DATE <u>JAN 8 '57</u>							

10500

DEPARTMENT OF HEALTH - BATHING

CERTIFICATE OF DEATH

Form No. 10

1. Usual Residence (House or Street)

2. Date of Death

3. Cause of Death

4. Place of Death

5. Medical Certification

6. Name of Physician

7. Name of Coroner

8. Name of Registrar

9. Name of Burial Place

10. Name of Undertaker

11. Name of Funeral Home

12. Name of Cemetery

13. Name of Interment

14. Name of Burial

15. Name of Burial

16. Name of Burial

17. Name of Burial

18. Name of Burial

19. Name of Burial

20. Name of Burial

BUREAU V. S.

JAN 9 1901

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00291

302

CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3401-4 Owings Mills Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood Training School</u>				d. STREET ADDRESS <u>3319 Liberty Heights Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>EMORY</u> First Middle Last <u>KUSZMAU</u>				4. DATE OF DEATH Month <u>1</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/6/36</u>		9. AGE (In years lost birthday) <u>20</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Emory Kuszmau</u>				14. MOTHER'S MAIDEN NAME <u>Viola May Younger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Father</u> Address <u>3319 Liberty Heights Baltimore, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration Pneumonia</u> DUE TO (b) <u>Pulmonary Tuberculosis</u> DUE TO (c) <u>Cerebral Spastic Quadriplegia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/21</u> , 19 <u>57</u> , to <u>1/28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/28/57</u> , 19 <u>57</u> , and that death occurred at <u>3:55 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ernest J. Decko</u>				ADDRESS (Street, city or town, state) <u>ROSEWOOD, Owings Mills</u> DATE SIGNED <u>1/28/57</u>			
PHYSICIAN'S NAME (Type) <u>Ernest J. Decko</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 31, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Self Funeral Home</u> ADDRESS <u>5205 York Rd Baltimore</u>				24a. REC'D BY REGISTRAR <u>Mary Elise</u> DATE <u>1-19-57</u>		24b. REGISTRAR'S SIGNATURE	

RESUME

BUREAU V. S.

JAN 30 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 0303
 CERTIFICATE OF DEATH

00292

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Delaware b. COUNTY Sussex			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 7 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millsboro 46x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS Route #2			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First DANIEL Middle B. Last LANGRALL				4. DATE OF DEATH Month January Day 11 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 29, 1910		9. AGE (In years last birthday) 46 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Shipping Company		11. BIRTHPLACE (State or foreign country) Oxford, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James F.H. Langrall				14. MOTHER'S MAIDEN NAME Margaret L. Bridges			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Clin. Rec., Vet. Administration Hospital, Ft. Howard Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) THROMBOSIS OF LEFT TEMPORAL LOBE 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from January 4 , 19 57 , to January 11 , 19 57 , that I last saw the deceased alive on January 11 , 19 57 , and that death occurred at 1:45 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 1/11/57 ACTUAL SIGNATURE Rolando D. Ponce de Leon M.D. PHYSICIAN'S NAME (Type) ROLANDO D. PONCE de LEON, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 1-12-57		22c. NAME OF CEMETERY OR CREMATORY Landing Neck Cemetery		22d. LOCATION (City, town, or county) (State) Trappe, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook Blight, Inc.				24a. REC'D BY REGISTRAR JAN 25 1957		24b. REGISTRAR'S SIGNATURE Lawson L. Farber	
25. FUNERAL HOME Ronald James Funeral Home, Millsboro, Delaware							

BUREAU V. S.

JAN 25 1957

RECEIVED

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

10803

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00293

Reg. Dist. No.

0304

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Wilson State Hospital</u>		d. STREET ADDRESS <u>CHURCH LAKE</u>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>LONG</u> Last <u>LONG</u>		4. DATE OF DEATH Month <u>1</u> Day <u>21</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>9-12-01</u> 9. AGE (In years last birthday) <u>55 1/2</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONTINENTAL CANCO.</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM LONG</u>		14. MOTHER'S MAIDEN NAME <u>THERESA TENTEROUGHT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>210-5558</u>	
17. INFORMANT Address <u>Hospital records, Mt. Wilson State Hospital</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>FAR ADVANCED PULMONARY TBC.</u> DUE TO (b) <u>002X</u> DUE TO (c) <u>12.29.55-1.21.57</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-29</u> , 19 <u>55</u> to <u>1-21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-21-57</u> , and that death occurred at <u>11</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>William Newcomer</u> M.D.		PHYSICIAN'S NAME (Type) <u>William Newcomer, M.D. Supt.</u> <u>Mt. Wilson, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-25-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Poplar Grove</u>	22d. LOCATION (City, town, or county) (State) <u>Cockeysville, Mdd</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>I. Scott Brooks</u> ADDRESS <u>622 York Rd., Towson 4, Md</u>		24a. REC'D BY REGISTRAR <u>AN 28 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Anthony Newells</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AN 28 MAY 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

305

CERTIFICATE OF DEATH

00294

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 18 days 360-4 Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor Nursing Home 5743 Edmondson Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Agnes Barbara Lorfing		4. DATE OF DEATH Jan. 30/57 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIAGE <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 5, 1897
9. AGE (In years last birthday) 59		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) I.W.		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Adam Bicask		14. MOTHER'S MAIDEN NAME Eve---	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Otto Lorfing		Address 3313 Liberty Heights Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain Tumor (glis blastoma) 193X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH approx. 4 mo.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-28 , 19 53 , to 1-30 , 19 57 , that I last saw the deceased alive on 1-28 , 19 57 , and that death occurred at 6:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stanley R Steinbach M.D. 3334 Dolefield Ave		DATE SIGNED	
PHYSICIAN'S NAME (Type) STANLEY R. STEINBACH		Baltimore 15, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF Jan. 30/57	
22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery		22d. LOCATION (City, town, or county) (State) Kansas City, Kansas	
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Witzke		ADDRESS 4101 Edmondson Ave	
24a. REC'D BY REGISTRAR Jan 31 57		DATE Witzke	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES BARBARA BROWN		FEBRUARY 1, 1957	
AGE		SEX	
65		F	
MARRIAGE		OCCUPATION	
MARRIED		HOUSEWIFE	
PLACE OF BIRTH		CITY OF DEATH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
CAUSE OF DEATH		MANNER OF DEATH	
HEART DISEASE		NATURAL	
IMMEDIATE CAUSE		FUNDAMENTAL DISEASE	
CORONARY ARTERY DISEASE		HYPERTENSION	
MORBIDITY		MORTALITY	
PREVIOUS ILLNESS		PREVIOUS SURGERY	
NONE		NONE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
J. B. BROWN		J. B. BROWN	

RECEIVED
FEB 1 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF HEALTH—BALTIMORE, 18

Item 4 FilmG209 1-15-57 et

CERTIFICATE OF DEATH

Reg. Dist. No.

00295

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 CATONSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CATON RIDGE NURSING HOME</u>		d. STREET ADDRESS <u>144 WADE AVE</u>	
3. NAME OF DECEASED (Type or print) First <u>COL FAX</u> Middle <u>LOWE</u> Last <u>LOWE</u>		4. DATE OF DEATH Month <u>January</u> Day <u>4</u> Year <u>19 57</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-3-1872</u>
9. AGE (In years last birthday) yrs. <u>84</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>	
11. BIRTHPLACE (State or foreign country) <u>YORK Co., PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>OBER LOWE</u>		14. MOTHER'S MAIDEN NAME <u>SARAH ANN KING</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Wm. Volland</u>		Address <u>Catonville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <u>Coronary arterio sclerosis</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>unk now</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF DEATH Hour <u>—</u> o. <u>11</u> p. <u>m.</u> Month <u>19</u> Day <u>4</u> Year <u>1957</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 1</u> , 19 <u>55</u> , to <u>Jan 4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 4</u> , 19 <u>57</u> , and that death occurred at <u>2:52</u> M; from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Cliff Ratliff, Jr.</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>4605 Edmonson ave 1/4/57</u>	
PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFF, JR.</u>		<u>4605 Edmonson ave 1/4/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-7-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Friends</u>	22d. LOCATION (City, town, or county) (State) <u>Town Home York Co., Penna.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth W. Whitham</u>		ADDRESS <u>Stewartstown Pa</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00296

197

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 Dundalk</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>6752 Woodley Road</u>	
3. NAME OF DECEASED (Type or print) <u>Frederick E. Saffy</u>		4. DATE OF DEATH <u>Jan 30 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 4 1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rubber Ret</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rubber Ret</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Frederick Saffy</u>		14. MOTHER'S MAIDEN NAME <u>Doris Krown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>6752 Woodley Rd</u>	
17. INFORMANT <u>Mr. Max Saffy</u>		Address <u>6752 Woodley Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>177x Carcinomatous</u> DUE TO <u>Cancer Prostate gland</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4 yrs.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 10</u> , 19 <u>57</u> , to <u>Jan 30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 30</u> , 19 <u>57</u> , and that death occurred at <u>3:45 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David H. Andrew</u> M.D.		ADDRESS (Street, city or town, state) <u>33 Dundalk Ave.</u>	
PHYSICIAN'S NAME (Type) <u>David H. Andrew M.D.</u>		DATE SIGNED <u>Dundalk Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Jan 31 1957</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Plum Creek</u>		22d. LOCATION (City, town, or county) (State) <u>New Kensington Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ulrich Funeral Home 2112 Dundalk</u>		ADDRESS <u>2112 Dundalk</u>	
24a. REC'D BY REGISTRAR <u>FEB 1 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Am. Kelly</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION	
DISEASE		INJURY		POISON	
SYMPTOMS		TREATMENT		HISTORY	
FAMILY HISTORY		PREVIOUS ILLNESS		MEDICAL HISTORY	
SOCIAL HISTORY		HABITS		RELIGION	
EDUCATION		MARRIAGE		CHILDREN	
BIRTH		DEATH		BURIAL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF WITNESSES	
DATE		TIME		PLACE	

BUREAU V. S.

FEB 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00297

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5 McCann Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LeLond Stanton Lynch</u>		4. DATE OF DEATH <u>January 21</u> 19 <u>57</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 10, 1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired Painter - Self Emp. Painting</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
13. FATHER'S NAME <u>Constantine Lynch</u>		14. MOTHER'S MAIDEN NAME <u>Mary Winters</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes</u> <u>World War I</u>		16. SOCIAL SECURITY NO. <u>218-01-7024</u>	
17. INFORMANT <u>Mr. Frederick C. Lynch - Box 166, Belair, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>10 Hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>		DATE SIGNED <u>1/21/57</u>	
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/25/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tichenor & Sons - Balto. 17, Md.</u>		24. REC'D BY REGISTRAR <u>Jan 25 1957</u> REGISTRAR'S SIGNATURE <u>Wm. J. Chulcontz</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NEW YORK STATE DEPARTMENT OF HEALTH - BATHING ORD. 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		MILITARY SERVICE		CIVIL SERVICE	
PREVAILING DISEASE		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH	
SIGNATURE OF EXAMINER		TITLE		ADDRESS		CITY		COUNTY		STATE	
SIGNATURE OF WITNESS		TITLE		ADDRESS		CITY		COUNTY		STATE	
SIGNATURE OF SECOND WITNESS		TITLE		ADDRESS		CITY		COUNTY		STATE	
SIGNATURE OF JURY		TITLE		ADDRESS		CITY		COUNTY		STATE	
SIGNATURE OF JUDGE		TITLE		ADDRESS		CITY		COUNTY		STATE	
SIGNATURE OF CLERK		TITLE		ADDRESS		CITY		COUNTY		STATE	
SIGNATURE OF NOTARY		TITLE		ADDRESS		CITY		COUNTY		STATE	
SIGNATURE OF CHURCH		TITLE		ADDRESS		CITY		COUNTY		STATE	
SIGNATURE OF SCHOOL		TITLE		ADDRESS		CITY		COUNTY		STATE	
SIGNATURE OF OTHER		TITLE		ADDRESS		CITY		COUNTY		STATE	

BUREAU V. S.

JAN 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

308

CERTIFICATE OF DEATH

Reg. Dist. No.

00298 37

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Falls Road				d. STREET ADDRESS Falls Road			
3. NAME OF DECEASED (Type or print) First LILLIAN Middle ELIZABETH Last MAINZ				4. DATE OF DEATH Month Jan. Day 11 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 20, 1869	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months 87 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Housewife			10b. KIND OF BUSINESS OR INDUSTRY Md.		11. BIRTHPLACE (State or foreign country) Md.		
13. FATHER'S NAME Isaac S. Crowther				14. MOTHER'S MAIDEN NAME Georgianna Kelly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Address Mrs. Lola M. Tinsley - 5219 Wilton Hgts. Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) myocarditis - chronic 443X DUE TO decompensated Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) hypertension DUE TO general arteriosclerosis - marked (c) marked						INTERVAL BETWEEN ONSET AND DEATH years 50 or more years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) yes WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ✓			
20c. TIME OF INJURY Month, Day, Year Hour a. p. ✓ 19 p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ✓	
20f. (City or town) ✓				20g. (County) ✓		20h. (State) ✓	
21. I certify that I attended the deceased from 12-1-1956 to 1-11-1957 , that I last saw the deceased alive on 1-10-1957 , and that death occurred at 5 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE James S. Saffell				ADDRESS (Street, city or town, state) Reisterstown Md			
PHYSICIAN'S NAME (Type) James S. Saffell				DATE SIGNED 1-14-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/15/57		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Thm. J. Tischer & Sons - Balto 17th				24a. REC'D BY REGISTRAR DATE 1/15/57		24b. REGISTRAR'S SIGNATURE H. H. Hedrick	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JOHN J. JAMES		2. SEX Male		3. AGE 45		4. DATE OF BIRTH JAN 15 1912		5. PLACE OF BIRTH BALTIMORE, MD.	
6. OCCUPATION Salesman		7. MARITAL STATUS Married		8. EDUCATION High School		9. RELIGION Roman Catholic		10. RACE White	
11. STREET ADDRESS 1234 E. BALTIMORE ST.		12. CITY BALTIMORE		13. STATE MD.		14. ZIP CODE 21201		15. COUNTY BALTIMORE	
16. DECEASED'S SIGNATURE John J. James		17. SIGNATURE OF PHYSICIAN Dr. J. H. Smith		18. SIGNATURE OF CLERK J. H. Smith		19. SIGNATURE OF WITNESS J. H. Smith		20. SIGNATURE OF DECEASED'S NEXT OF KIN Mrs. J. H. Smith	
21. DATE OF DEATH JAN 16 1957		22. TIME OF DEATH 10:00 AM		23. PLACE OF DEATH Home		24. CAUSE OF DEATH Heart Disease		25. MANNER OF DEATH Natural	
26. MEDICAL HISTORY None		27. SURGICAL HISTORY None		28. PRESENT ILLNESS None		29. TREATMENT None		30. OTHER NOTES None	

BUREAU V. S.

JAN 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

198

CERTIFICATE OF DEATH

00299

Reg. Dist. No. 41

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk 22</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk 22</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>523 New Pittsburgh Ave.</u>		STREET ADDRESS (If rural, give location) <u>523 New Pittsburgh Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Ernest</u> (Middle) <u>Lester</u> (Last) <u>McClary</u>	4. DATE OF DEATH (Month) <u>January</u> (Day) <u>24</u> (Year) <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>16 May 1910</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel Unloader</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel Plant</u>	9. AGE last birthday <u>46</u> yrs. If under 1 year Months <u>9</u> Days <u>3</u> Hours <u>3</u> Mins. <u>3</u>
11a. BIRTHPLACE (State or foreign country) <u>Salters, S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Prince McClary</u>		14. MOTHER'S M maiden name <u>Margtha</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>World War II</u>		16. SOCIAL SECURITY NO. <u>224-07-7859</u>	
17. INFORMANT AND ADDRESS <u>Minnie L. McClary 523 New Pittsburgh Ave. #22</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Broncho-pneumonia

INTERVAL BETWEEN ONSET AND DEATH

2 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 1-23-, 1957, to 1-24-, 1957, that I last saw the deceased

alive on 1-24-, 1957, and that death occurred at 12:25 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>1/28/57</u>	NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	LOCATION (City, town, or county) <u>Baltimore, Maryland</u>	(State)
DATE REC'D BY LOCAL REG. <u>1/25/57</u>	REGISTRAR'S SIGNATURE <u>Thm. J. Kelly</u>	24. FUNERAL DIRECTOR <u>Charles R. Law</u>	ADDRESS <u>802 Madison Avenue</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

JAN 29 1957

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for and to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00300

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carney				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carney			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9909 Finney Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Marian Middle L. Last McCleary				4. DATE OF DEATH Month January Day 25 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1923 Feb-24-1923	
9. AGE (In years last birthday) 33 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) cafeteria		10b. KIND OF BUSINESS OR INDUSTRY Black & Decker		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Isennoek		14. MOTHER'S MAIDEN NAME Neva Campbell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-32-3512		17. INFORMANT James L. Mc Cleary (same)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of abdomen DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self in abdomen					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 1/25/ 1957 p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) (County) (State) Baltimore Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE William V. Lovitt, Jr. M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-28-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Chas F. Evans & Son 8802 Harford Rd.				24a. REC'D BY REGISTRAR Jan 29 1957		24b. REGISTRAR'S SIGNATURE Dr. A. M. B...	

JAN 29 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

310

CERTIFICATE OF DEATH

00301

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u> ✓	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		LENGTH OF STAY (in this place) <u>5 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis (Winchester on Severn)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Paradise Nursing Home</u>				STREET ADDRESS (If rural give location) <u>Rt 4 Box 161 02X02</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>LEILA MAY MCGILLIVRAY</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JANUARY 31 19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 9, 1872</u>	9. AGE last birthday <u>84 yrs.</u>	IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Elisha Turner Sentell</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Jane Condon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Mr Archie McGillivray-Son- same as # 2</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<u>24 hrs</u>	
4221 IMMEDIATE CAUSE (A) <u>Cerebral thromboses</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>ASCVD, grade III</u>						<u>Unknown</u>	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 20</u> , 19 <u>52</u> , to <u>Jan 31</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 30</u> , 19 <u>57</u> , and that death occurred at <u>2:07</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Stephen Lee Higgins</u>		M.D. <u>908 Catonsville Rd</u>		ADDRESS (Street, city, town, state) <u>Birmingham, Alabama</u>		DATE SIGNED <u>1-31-57</u>	
23. BURIAL CREMATION, REMOVAL (SPECIFY) <u>Burial-Removal</u>		DATE THEREOF <u>Feb 2 57</u>		NAME OF CEMETERY OR CREMATORY <u>Elmwood Cemetery</u>		LOCATION (City, town, or county) (State) <u>Birmingham, Alabama</u>	
24. REC'D BY REGISTRAR <u>W. H. Beach</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Beach</u>		ADDRESS <u>HOPKINS FUNERAL HOME Annapolis, Md.</u>	
DATE <u>FEB 4 '57</u>							

SHORT SYSTEM

THIS SYSTEM IS DESIGNED TO BE USED IN CONNECTION WITH THE SHORT SYSTEM OF RECORDS AND IS NOT TO BE USED IN CONNECTION WITH THE LONG SYSTEM OF RECORDS. THE SHORT SYSTEM OF RECORDS IS A SYSTEM OF RECORDS WHICH IS DESIGNED TO BE USED IN CONNECTION WITH THE SHORT SYSTEM OF RECORDS. THE LONG SYSTEM OF RECORDS IS A SYSTEM OF RECORDS WHICH IS DESIGNED TO BE USED IN CONNECTION WITH THE LONG SYSTEM OF RECORDS. THE SHORT SYSTEM OF RECORDS IS A SYSTEM OF RECORDS WHICH IS DESIGNED TO BE USED IN CONNECTION WITH THE SHORT SYSTEM OF RECORDS. THE LONG SYSTEM OF RECORDS IS A SYSTEM OF RECORDS WHICH IS DESIGNED TO BE USED IN CONNECTION WITH THE LONG SYSTEM OF RECORDS.

CERTIFICATE OF DEATH

100001

BUREAU V. S.

FEB 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00302

311

CERTIFICATE OF DEATH

Reg. Dist. No.

335

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural White Hall</u>		c. LENGTH OF STAY IN 1b <u>23 yrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural White Hall</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Amenda</u> Middle <u>Zaneth</u> Last <u>McGinnis</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>8</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 7, 1868</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ephraim B. McClung</u>		14. MOTHER'S MAIDEN NAME <u>Hannah Elizabeth Wiley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>John T. McGinnis, White Hall RD, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarct</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerosis advanced</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>15 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>50</u> , to <u>1-6-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-6-</u> , 19 <u>57</u> , and that death occurred at <u>7:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William O. Fulton</u> M.D.		ADDRESS (Street, city or town, state) <u>Stewartstown, Pa.</u> DATE SIGNED <u>1-9-57</u>	
PHYSICIAN'S NAME (Type) <u>William O. Fulton</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-11-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Centre Presby.</u>		22d. LOCATION (City, town, or county) (State) <u>New Park, York Co., Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth W. Chisholm</u>		ADDRESS <u>Stewartstown, Penna.</u>	
24a. REC'D BY REGISTRAR <u>1/10/57</u>		24b. REGISTRAR'S SIGNATURE <u>Robert J. Fulton</u>	

BUREAU V. S.

JAN 15 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2mth4dys	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown, Maryland	
3. NAME OF DECEASED (Type or print) First John Middle J. McGuire Last McGuire		4. DATE OF DEATH Month January Day 9, Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH unknown
9. AGE (In years last birthday) 69yrs.		IF UNDER 1 YEAR Months 69 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) stock accountant		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (State or foreign country) Ireland?		12. CITIZEN OF WHAT COUNTRY? U. S. A.?	
13. FATHER'S NAME John McGuire		14. MOTHER'S MAIDEN NAME Mary McGuire	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) yes		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary thrombosis and infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Infarctive myocardial fibrosis DUE TO (c) Arteriosclerotic cardiovascular disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of right hip			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pt. slipped in tub while bathing, sustaining frac. right femur.	
20c. TIME OF INJURY Month, Day, Year 10:00 a.m. 12-28 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital		20f. (City or town) (County) (State) Catonsville 28, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>George M. Kieffer</i>		DATE SIGNED Jan 10 1957	
EXAMINER'S NAME (Type) George M. Kieffer, M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/14/57	
22c. NAME OF CEMETERY OR CREMATORY Baltimore Nat.		22d. LOCATION (City, town, or county) (State) Frederick Md.	
23. FUNERAL DIRECTOR'S SIGNATURE G. J. Fahy & Sons		ADDRESS 1318 Light St.	
24a. REC'D BY REGISTRAR Jan 15 1957		24b. REGISTRAR'S SIGNATURE <i>Arthur</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 8

JAN 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

199

CERTIFICATE OF DEATH

Reg. Dist. No.

00304

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY Dundalk	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 55 Broadship Road		d. STREET ADDRESS 1 53 Broadship	
3. NAME OF DECEASED (Type or print) J Clyde McIntire		4. DATE OF DEATH Jan 3/56 Month Day Year	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 27, 1903
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done for most of working life, even if retired) neural metallurgist		10b. KIND OF BUSINESS OR INDUSTRY Beth Steel	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Mc Intire		14. MOTHER'S MAIDEN NAME Lucy Goode	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO.	
17. INFORMANT Violet McIntire 53 Broadship		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY ARTERY DISEASE DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 minutes 2-3 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-19- , 19 56 , to 12-31- , 19 56 , that I last saw the deceased alive on 12-31-56 , 19 56 , and that death occurred at 1:45 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE W E Baermann M.D.		ADDRESS (Street, city or town, state) DR. W. E. BAERMANN 33 DUNDALK AVENUE DUNDALK 22, MARYLAND	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF Jan 5/57	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore Co
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral 2112 Dundalk Ave		24a. REG'D BY REGISTRAR JAN 8 1957 DATE	
24b. REGISTRAR'S SIGNATURE Wm. M. Kelly			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A. B.

1957 8 NOV 27 3 34 PM

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

313

CERTIFICATE OF DEATH

00305

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Louisiana</u> b. COUNTY <u>New Orleans</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. LENGTH OF STAY IN 1b <u>20 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sheppard-Enoch Pratt Hosp.</u>				d. STREET ADDRESS <u>7327 Sycamore St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Nora</u> First Middle Last <u>McGloin McLoughlin</u>				4. DATE OF DEATH Month <u>1</u> Day <u>31</u> Year <u>1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-13-1873</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>Louisiana</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Frank McGloin</u>				14. MOTHER'S MAIDEN NAME <u>Alice Kleinpeter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Frank McLoughlin 3004 Coliseum St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Major Depressive Psychosis, Mixed Type</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>—</u> p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>May 6</u> , 19 <u>37</u> , to <u>1-31</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-30</u> , 19 <u>57</u> , and that death occurred at <u>7:15</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W.W. Elgin</u>				ADDRESS (Street, city or town, state) <u>Sheppard Pratt Hosp.</u> DATE SIGNED <u>1/31/57</u>			
PHYSICIAN'S NAME (Type) <u>W.W. Elgin</u>				Towson - 4. Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/3/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Patrick Cem. #3</u>		22d. LOCATION (City, town, or county) (State) <u>New Orleans, La.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lickner & Sons - Balto</u>				24a. REC'D BY REGISTRAR <u>EB 1</u> 1957 24b. REGISTRAR'S SIGNATURE <u>Mabel Gray</u>			

BUREAU V. S.

FEB 4 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No. 00306										
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY ✓					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN TB 5mth23dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3401.4			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL					d. STREET ADDRESS 1012 Forrest St. * Balto. 2, Md.					
3. NAME OF DECEASED (Type or print) First Daisy Middle O Last McQuay					4. DATE OF DEATH Month January Day 7 Year 19 57					
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 19 1885 unknown		9. AGE (In years last birthday) 71 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife (Pecker)		10b. KIND OF BUSINESS OR INDUSTRY McCormick & Co		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME unknown Gustavus Jones					14. MOTHER'S MAIDEN NAME unknown Sutton Hunt					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.1 Congestive heart failure DUE TO Inanition & dehydration Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pending DUE TO Psychosis with Cerebral Arteriosclerosis (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								INTERVAL BETWEEN ONSET AND DEATH		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) pt. fell on 12-27-56 sustaining laceration of forehead on right side.						
20c. TIME OF INJURY Month, Day, Year 5:00 p.m. 12-27-56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital		20f. (City or town) Catonsville 28, Md.		(County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE Geo. S. M. Kieffer EXAMINER'S NAME (Type) George M. Kieffer, M. D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 1-11-57		22c. NAME OF CEMETERY OR CREMATORY Moreland		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street					24a. REC'D BY REGISTRAR DATE 1/10/57		24b. REGISTRAR'S SIGNATURE R. H. Hedrick			

BUREAU V. 3

JAN 11 1957

RECEIVED

315

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 Catonsville - 28 -</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>DANIEL A MEEHAN</u>				4. DATE OF DEATH Month Day Year <u>1 23 1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-3-1882</u>	9. AGE (In years last birthday) yrs. <u>75</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Labour</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Michael Meehan</u>				14. MOTHER'S M maiden name <u>Elizabeth Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mrs Mary Meehan</u>				Address <u>14 Ridge Rd 28</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332X Cardio Respiratory failure.</u> DUE TO (b) <u>Cerebral Vascular Thrombosis</u> DUE TO (c) <u>Arteriosclerosis, generalized, severe</u>							INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>10 Jan 1957</u> , to <u>23 Jan 1957</u> , that I last saw the deceased alive on <u>23 Jan 1957</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William J. Bryson</u> M.D.				DATE SIGNED <u>25 Jan 1957</u>			
PHYSICIAN'S NAME (Type) <u>William J. Bryson</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <input checked="" type="checkbox"/>		22c. NAME OF CEMETERY OR CREMATORY <u>Good Shepherd</u>		22d. LOCATION (City, town, or county) (State) <u>Elkton City - MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marshall Son - Catonsville - 18 - MD</u>				24a. REC'D BY REGISTRAR <u>28 57</u>		24b. REGISTRAR'S SIGNATURE <u>DeLoach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 28 1957

BUREAU V. 2

MAY AND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.	
CERTIFICATE OF DEATH	
1. NAME OF DECEASED	
2. SEX	
3. AGE	
4. DATE OF BIRTH	
5. PLACE OF BIRTH	
6. OCCUPATION	
7. CAUSE OF DEATH	
8. PLACE OF DEATH	
9. TIME OF DEATH	
10. SIGNATURE OF DECEASED	
11. SIGNATURE OF WITNESS	
12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF CORONER	
14. SIGNATURE OF JURY	
15. SIGNATURE OF JUDGE	
16. SIGNATURE OF CLERK	
17. SIGNATURE OF NOTARY	
18. SIGNATURE OF SHERIFF	
19. SIGNATURE OF DEPUTY SHERIFF	
20. SIGNATURE OF JAILER	
21. SIGNATURE OF WARDEN	
22. SIGNATURE OF CHANCELLER	
23. SIGNATURE OF CLERK OF COURT	
24. SIGNATURE OF JUDGE OF PROBATE	
25. SIGNATURE OF JUDGE OF COMMON PLEAS	
26. SIGNATURE OF JUDGE OF ORphans' COURT	
27. SIGNATURE OF JUDGE OF MENTAL HOSPITAL	
28. SIGNATURE OF JUDGE OF COUNTY JAIL	
29. SIGNATURE OF JUDGE OF COUNTY PRISON	
30. SIGNATURE OF JUDGE OF COUNTY ASYLUM	
31. SIGNATURE OF JUDGE OF COUNTY HOSPITAL	
32. SIGNATURE OF JUDGE OF COUNTY WORKHOUSE	
33. SIGNATURE OF JUDGE OF COUNTY FARM	
34. SIGNATURE OF JUDGE OF COUNTY MILL	
35. SIGNATURE OF JUDGE OF COUNTY LUMBER YARD	
36. SIGNATURE OF JUDGE OF COUNTY SAWMILL	
37. SIGNATURE OF JUDGE OF COUNTY BRICK YARD	
38. SIGNATURE OF JUDGE OF COUNTY POTTERY	
39. SIGNATURE OF JUDGE OF COUNTY CLOTHING	
40. SIGNATURE OF JUDGE OF COUNTY FURNITURE	
41. SIGNATURE OF JUDGE OF COUNTY CARPENTRY	
42. SIGNATURE OF JUDGE OF COUNTY BLACKSMITH	
43. SIGNATURE OF JUDGE OF COUNTY WHEELWRIGHT	
44. SIGNATURE OF JUDGE OF COUNTY COBBLER	
45. SIGNATURE OF JUDGE OF COUNTY SHOE REPAIRER	
46. SIGNATURE OF JUDGE OF COUNTY HAT MAKER	
47. SIGNATURE OF JUDGE OF COUNTY MILLINER	
48. SIGNATURE OF JUDGE OF COUNTY DRESSMAKER	
49. SIGNATURE OF JUDGE OF COUNTY TAILOR	
50. SIGNATURE OF JUDGE OF COUNTY HATTER	
51. SIGNATURE OF JUDGE OF COUNTY MILLINERY	
52. SIGNATURE OF JUDGE OF COUNTY DRESSMAKING	
53. SIGNATURE OF JUDGE OF COUNTY TAILORING	
54. SIGNATURE OF JUDGE OF COUNTY HAT MAKING	
55. SIGNATURE OF JUDGE OF COUNTY MILLINERY	
56. SIGNATURE OF JUDGE OF COUNTY DRESSMAKING	
57. SIGNATURE OF JUDGE OF COUNTY TAILORING	
58. SIGNATURE OF JUDGE OF COUNTY HAT MAKING	
59. SIGNATURE OF JUDGE OF COUNTY MILLINERY	
60. SIGNATURE OF JUDGE OF COUNTY DRESSMAKING	
61. SIGNATURE OF JUDGE OF COUNTY TAILORING	
62. SIGNATURE OF JUDGE OF COUNTY HAT MAKING	
63. SIGNATURE OF JUDGE OF COUNTY MILLINERY	
64. SIGNATURE OF JUDGE OF COUNTY DRESSMAKING	
65. SIGNATURE OF JUDGE OF COUNTY TAILORING	
66. SIGNATURE OF JUDGE OF COUNTY HAT MAKING	
67. SIGNATURE OF JUDGE OF COUNTY MILLINERY	
68. SIGNATURE OF JUDGE OF COUNTY DRESSMAKING	
69. SIGNATURE OF JUDGE OF COUNTY TAILORING	
70. SIGNATURE OF JUDGE OF COUNTY HAT MAKING	
71. SIGNATURE OF JUDGE OF COUNTY MILLINERY	
72. SIGNATURE OF JUDGE OF COUNTY DRESSMAKING	
73. SIGNATURE OF JUDGE OF COUNTY TAILORING	
74. SIGNATURE OF JUDGE OF COUNTY HAT MAKING	
75. SIGNATURE OF JUDGE OF COUNTY MILLINERY	
76. SIGNATURE OF JUDGE OF COUNTY DRESSMAKING	
77. SIGNATURE OF JUDGE OF COUNTY TAILORING	
78. SIGNATURE OF JUDGE OF COUNTY HAT MAKING	
79. SIGNATURE OF JUDGE OF COUNTY MILLINERY	
80. SIGNATURE OF JUDGE OF COUNTY DRESSMAKING	
81. SIGNATURE OF JUDGE OF COUNTY TAILORING	
82. SIGNATURE OF JUDGE OF COUNTY HAT MAKING	
83. SIGNATURE OF JUDGE OF COUNTY MILLINERY	
84. SIGNATURE OF JUDGE OF COUNTY DRESSMAKING	
85. SIGNATURE OF JUDGE OF COUNTY TAILORING	
86. SIGNATURE OF JUDGE OF COUNTY HAT MAKING	
87. SIGNATURE OF JUDGE OF COUNTY MILLINERY	
88. SIGNATURE OF JUDGE OF COUNTY DRESSMAKING	
89. SIGNATURE OF JUDGE OF COUNTY TAILORING	
90. SIGNATURE OF JUDGE OF COUNTY HAT MAKING	
91. SIGNATURE OF JUDGE OF COUNTY MILLINERY	
92. SIGNATURE OF JUDGE OF COUNTY DRESSMAKING	
93. SIGNATURE OF JUDGE OF COUNTY TAILORING	
94. SIGNATURE OF JUDGE OF COUNTY HAT MAKING	
95. SIGNATURE OF JUDGE OF COUNTY MILLINERY	
96. SIGNATURE OF JUDGE OF COUNTY DRESSMAKING	
97. SIGNATURE OF JUDGE OF COUNTY TAILORING	
98. SIGNATURE OF JUDGE OF COUNTY HAT MAKING	
99. SIGNATURE OF JUDGE OF COUNTY MILLINERY	
100. SIGNATURE OF JUDGE OF COUNTY DRESSMAKING	

1

316

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G209 1-18-57 et

CERTIFICATE OF DEATH

00308

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harmonville</u> c. LENGTH OF STAY IN 1b <u>6 MOS.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u> d. STREET ADDRESS <u>974 Chesapeake Dr.</u> <u>Batonville Maryland</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Leo</u> Middle <u>HERMAN</u> Last <u>Meyer</u>				4. DATE OF DEATH Month <u>January</u> Day <u>13</u> Year <u>1957</u>					
5. SEX <u>M.</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-11-1878</u>		9. AGE (In years last birthday) <u>78</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Otto Meyer</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Samsel</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Harold Meyers</u> Address <u>974 Chesapeake Dr. Harre de Grace 707</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic cardio-vascular disease</u> DUE TO (c) <u>Indeterminate</u>								INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 3, 1955</u> , to <u>January 13, 1957</u> , that I last saw the deceased alive on <u>January 13, 1957</u> , and that death occurred at <u>9:45 A.M.</u> from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Charles Ward</u> M.D.				ADDRESS (Street, city or town, state) <u>Spring Grove Hosp. 1/13/57</u>					
PHYSICIAN'S NAME (Type) <u>DR. CHARLES WARD</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-16-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>SYRACUSE, ONONDAGA, N.Y.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>K. Madison Mitchell</u>				ADDRESS <u>Harre de Grace, Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 16 57</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Search</u>	

JAN 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00309

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN TB 8mth25dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis, Maryland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 02-10-23 Eastern Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Freeman Last Miller				4. DATE OF DEATH Month January Day 19 Year 19 57			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 12, 1874		9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months 82 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired minister		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Miller				14. MOTHER'S MAIDEN NAME Nancy Rerr			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO Generalized Atherosclerotic disease Conditions, if any, which gave rise to immediate cause (b) 904.8 (c) fracture of left femur PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) On 11-30-56 pt. was discovered to have fracture of left femur. No one knows how injury occurred.							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OF CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) discovered to have fracture of left femur. No one knows how injury occurred.		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Catonsville 28, Md.	
20c. TIME OF INJURY Month, Day, Year Hour 12:00 m. 11-30-56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Catonsville 28, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE G. M. Kieffer EXAMINER'S NAME (Type) George M. Kieffer, M. D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-21-57		22c. NAME OF CEMETERY OR CREMATORY St Annes		22d. LOCATION (City, town, or county) (State) Annapolis Md	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Saylor Sons ADDRESS Annapolis Md				24a. REC'D BY REGISTRAR DATE 1/21/57			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		PREVIOUS ILLNESS		CAUSE OF DEATH		MANNER OF DEATH		TIME OF DEATH		PLACE OF DEATH	
SIGNATURE OF EXAMINER		DATE		TIME		PLACE		CITY		STATE		COUNTRY		HOSPITAL		PHYSICIAN	

RECEIVED
 JAN 23 1957
 BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00310

318

CERTIFICATE OF DEATH

Reg. Dist. No.

45

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex c. LENGTH OF STAY IN 1b 54 Essex d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10 BRANCH ST		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Branch St. Balto. 21 Md. d. STREET ADDRESS 10 Branch St. Balto. 21 Md. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Mitchell Last Mitchell		4. DATE OF DEATH Month January Day 18 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/24/1907 9. AGE (In years last birthday) 49 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Md.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Lee A. Kerr		14. MOTHER'S MAIDEN NAME Minnie Ely	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Harry C. Mitchell		Address (same as above)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Azotemia, chronic 602X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bilateral calculus pyonephrosis. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive cardiovascular disease.		INTERVAL BETWEEN ONSET AND DEATH 4 yrs 15 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 47 , to Jan. , 19 57 , that I last saw the deceased alive on Jan. , 19 57 , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Ridge Road DATE SIGNED 1/18/57			
ACTUAL SIGNATURE Harvey L. Fuller		M.D. Ridge Road	
PHYSICIAN'S NAME (Type) HARVEY L. FULLER, M.D.		Baltimore 6, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1122157	
22c. NAME OF CEMETERY OR CREMATORY Sacred Heart		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Connelly		ADDRESS Balto. 21 Md.	
24a. REC'D BY REGISTRAR JAN 22 1957		24b. REGISTRAR'S SIGNATURE Edith Hurley	

BUREAU V. S.

JAN 25 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg, Md. 16332	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 4208 Edmondson Avenue	
3. NAME OF DECEASED (Type or print) First Evie Middle Smith Last Montgomery		4. DATE OF DEATH Month January Day 20 Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1869
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Mississippi		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Leon Smith		14. MOTHER'S MAIDEN NAME Molly ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records; SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized and severe DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 1, 1956 to Jan. 20, 1957 , that I last saw the deceased alive on Jan. 20, 1957 , and that death occurred at 8:20 P M , from the causes and on the date stated above.			
ACTUAL SIGNATURE Louise Frances Woodward M.D.		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED Jan. 20, 1957	
PHYSICIAN'S NAME (Type) Louise Frances Woodward		Catonsville 28, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation		22b. DATE THEREOF 1/21/57	
22c. NAME OF CEMETERY OR CREMATORY Canton		22d. LOCATION (City, town, or county) (State) Mississippi	
23. FUNERAL DIRECTOR'S SIGNATURE L. Pasch		ADDRESS Hyattsville Md	
24a. REC'D BY REGISTRAR DATE JAN 24 '57		24b. REGISTRAR'S SIGNATURE Reber	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 24 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

320

CERTIFICATE OF DEATH

00312

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Whitehall</u>		c. LENGTH OF STAY IN 1b <u>14 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Old York Rd.</u>		d. STREET ADDRESS <u>Old York Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>C.</u> Last <u>Mooney</u>		4. DATE OF DEATH Month <u>January</u> Day <u>3</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 22 1874</u>
9. AGE (In years less birthday) <u>82</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>County Clare, Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Ann Neigent</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>John Heiser - White Hall, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>332x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio-sclerosis</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/1/57</u> , 19 <u>57</u> , to <u>1/3/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/3/57</u> , 19 <u>57</u> , and that death occurred at <u>12:10 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. M. France</u>		ADDRESS (Street, city or town, state) <u>PARKTON, Md.</u>	
PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>		DATE SIGNED <u>1/4/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/7/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Jacob Hartenstein</u>		24a. REC'D BY REGISTRAR <u>1/7/57</u>	
ADDRESS <u>New Freedom, Pa.</u>		24b. REGISTRAR'S SIGNATURE <u>Clara J. Eudon</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00313

321 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

37

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville</u>		c. LENGTH OF STAY IN 1b <u>In transit</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Owings Mills</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Stevenson Rd.</u>				d. STREET ADDRESS <u>Timber Grove Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Franklin Murray</u>				4. DATE OF DEATH Month Day Year <u>Jan. 13, 1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 7, 1938</u>		9. AGE (In years last birthday) <u>18</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wm. F. Chew Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Franklin Murray Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Evelyn E. Rittenhouer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>William F. Murray, Owings Mills, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured skull, crushed chest, fracture of left shoulder and left femur due to auto accident.</u> 823X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>auto accident.</u> (c) <u>stolting the underlying cause lost.</u> DUE TO							INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>no</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Struck culvert.</u>					
20c. TIME OF INJURY Month, Day, Year <u>12 MN o. m. Jan. 12 19 57</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Stevenson Rd.,</u>		20f. (City or town) (County) (State) <u>Stevenson Balto. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>D. D. Caples</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>D.D. Caples, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 15, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Deer Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Owings Mills, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank A. Howell</u>				24a. REC'D BY REGISTRAR <u>JAN 15 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dorothy Newell</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enter cause of death, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

JAN 15 1957

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The birth certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00314

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		LENGTH OF STAY (in this place) <u>4 YRS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		TOWN <u>22</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>563 BAYSIDE Rd</u>				STREET ADDRESS (If rural give location) <u>503 BAYSIDE Rd</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>ANNA</u> (Middle) <u>BROWN</u> (Last) <u>WEBINGER</u>				(Month) <u>1-25-</u> (Day) <u>19</u> (Year) <u>57</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>WIDOW</u>	8. DATE OF BIRTH <u>SEPT 8, 1870</u>	9. AGE last birthday <u>86</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNK</u>				14. MOTHER'S MAIDEN NAME <u>UNK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NOT RECORDED</u>		17. INFORMANT & ADDRESS <u>ROBT. WEBINGER - SAME</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
443X IMMEDIATE CAUSE (A) <u>Hypertensive Cardio-Vascular Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>—</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>—</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>—</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YE: <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>—</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>—</u>			
22. I hereby certify that I attended the deceased from <u>Jan 4, 1949</u> , to <u>Jan 25, 1957</u> , that I last saw the deceased alive on <u>Jan 25, 1957</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>E. A. Evans</u>		DATE THEREOF <u>1-28-57</u>		NAME OF CEMETERY OR CREMATORY <u>EMANUEL</u>		LOCATION (City, town, or county) (State) <u>LEWISBERRY, PA</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		24. REC'D BY REGISTRAR <u>Wm. Kelly</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Smith Headley, Dundalk MD</u>		DATE SIGNED <u>1-25-57</u>	
DATE <u>JAN 28 1957</u>							

CERTIFICATE OF DEATH

Reg. Dist. No.

1. Usual Residence (Home or Place)

2. Date of Death

3. Cause of Death

4. Place of Death

5. Age

6. Sex

7. Race

8. Marital Status

9. Occupation

10. Date of Birth

11. Date of Admission

12. Date of Discharge

13. Date of Death

14. Date of Death

15. Date of Death

16. Date of Death

17. Date of Death

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BUREAU V. 3

JAN 28 1957

RECEIVED

322

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 52			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1333 Valleybrook Road				d. STREET ADDRESS 1333 Valleybrook Road			
3. NAME OF DECEASED (Type or print) MAUDE BELL NEELY				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Female				6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF DEATH Jan 30 1957				9. AGE (In years last birthday) 67 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Samuel Green			
14. MOTHER'S MAIDEN NAME Katherine Sherman				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war and dates of service)			
16. SOCIAL SECURITY NO. —				17. INFORMANT Alfred S. Neely Address 1333 Valleybrook Rd			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adeno - Carcinoma of colon 153X DUE TO (b) Arterio - Sclerotic Heart Disease DUE TO (c) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH 3 yrs. 1 yr.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.0				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from Aug - 1954 to Jan - 30 - 1957 , that I last saw the deceased alive on Jan - 30 - 1957 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Earl L. Chambers M.D. 4108 Liberty Heights Baltimore MD				DATE SIGNED 2/1/57			
PHYSICIAN'S NAME (Type) DR. EARL L. CHAMBERS				ADDRESS (Street, city or town, state) 4108 LIBERTY HEIGHTS BALTIMORE MD			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Feb 2, 1957		London Park		Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE John F. Trefel ADDRESS 5311 Edmondson Ave				24a. REC'D BY REGISTRAR Feb 1 57		24b. REGISTRAR'S SIGNATURE Arthur	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>NAME OF DECEASED WILLIAM</p>		<p>DATE OF DEATH 1957</p>	
<p>PLACE OF DEATH BALTIMORE</p>		<p>AGE 45</p>	
<p>SEX MALE</p>		<p>RACE WHITE</p>	
<p>DATE OF BIRTH 1912</p>		<p>PLACE OF BIRTH MARYLAND</p>	
<p>CAUSE OF DEATH HEART DISEASE</p>		<p>IMMEDIATE CAUSE MYOCARDIAL INFARCTION</p>	
<p>DATE OF DEATH 1957</p>		<p>PLACE OF DEATH BALTIMORE</p>	
<p>SEX MALE</p>		<p>RACE WHITE</p>	
<p>DATE OF BIRTH 1912</p>		<p>PLACE OF BIRTH MARYLAND</p>	
<p>CAUSE OF DEATH HEART DISEASE</p>		<p>IMMEDIATE CAUSE MYOCARDIAL INFARCTION</p>	

BUREAU V. S.

FEB 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

323

CERTIFICATE OF DEATH

Reg. Dist. No. 0031644

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 99 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 3614 1329 Park Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DUDLEY Middle F. Last NICHOLSON		4. DATE OF DEATH Month January Day 8 Year 1957					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 2, 1892	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY Bank		11. BIRTHPLACE (State or foreign country) Mt. Washington, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edwin C. Nicholson				14. MOTHER'S MAIDEN NAME Camilla Dunkel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA, LEFT LUNG, WITH CEREBRAL METASTASES DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 1, 1956 , to January 8, 1957 , that death occurred at 1:50 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Irving Freeman M.D. Veterans Administration Hospital 1/8/57							
ACTUAL SIGNATURE Irving Freeman M.D. Veterans Administration Hospital 1/8/57							
PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Chief Medical Service, VAH, Fort Howard, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-10-57		22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Stewart and Mowen Co., 108 W. North Ave., Balto. Md.				24a. REC'D BY REGISTRAR 9 1957		24b. REGISTRAR'S SIGNATURE Lawson L. Farber	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

324

CERTIFICATE OF DEATH

00317

Reg. Dist. No.

43

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton</u>				c. LENGTH OF STAY IN 1b <u>10</u> Fullerton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 110 Schroeder Ave</u>				d. STREET ADDRESS <u>Box 110 Schroeder Ave</u>			
3. NAME OF DECEASED (Type or print) <u>Mrs. Kathleen V. Nickles</u>				4. DATE OF DEATH Month <u>January</u> Day <u>8th</u> Year <u>1957</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 3, 1932</u>	
9. AGE (In years last birthday) <u>24</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Joseph Harrison</u>				14. MOTHER'S MAIDEN NAME <u>Marie Nelson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mr. Donald Edward Nickles, Sr.</u>				Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. j. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Jan 2</u> , 19 <u>57</u> , to <u>Jan 8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 7</u> , 19 <u>57</u> , and that death occurred at <u>3:15 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Coral Gordon</u>				ADDRESS (Street, city or town, state) <u>300 E. North Ave</u>			
DATE SIGNED <u>Jan 10 1957</u>				PHYSICIAN'S NAME (Type) <u>Coral Gordon</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/11/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>				ADDRESS <u>5305 Harford Road #14</u>		24a. REC'D BY REGISTRAR <u>Jan 10 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Mrs. C. L. Ruffeider</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4-1
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00318

CERTIFICATE OF DEATH

Reg. Dist. No.

325

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 412 Overbrook		d. STREET ADDRESS 1 412 Overbrook Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lawrence Middle Edward Last Noone		4. DATE OF DEATH Month Jan. Day 5 Year 19 57	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 12, 1900
9. AGE (In years lost birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical Contractor, Noone Elet. Co.		10b. KIND OF BUSINESS OR INDUSTRY Maryland.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Patrick T. Noone		14. MOTHER'S MAIDEN NAME Rosa M. Starry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-09-1378	
17. INFORMANT Mrs Wilhelmina Noone		Address 412 Overbrook Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, Urinary Bladder 187x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. 1 p. m. Month, Day, Year 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 49 , to January , 19 57 , that I last saw the deceased alive on Jan. 5 , 19 57 , and that death occurred at 11:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Geo J. Gaver M.D. 1 Mallow Hill Ave., Baltimore, Md. 1/7/57 PHYSICIAN'S NAME (Type) Leo J. Gaver, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		22b. DATE THEREOF Jan. 9/57	
22c. NAME OF CEMETERY OR CREMATORY Lorraine Park		22d. LOCATION (City, town, or county) (State) Woodlawn Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Witke		ADDRESS 4101 Edmondson Ave	
24a. REC'D BY REGISTRAR JAN 9 '57		24b. REGISTRAR'S SIGNATURE Overbrook	

RECEIVED

JAN 9 1957

BUREAU V. 2

1. NAME OF DECEASED		2. DATE OF DEATH	
3. PLACE OF DEATH		4. SEX	
5. RACE		6. AGE	
7. OCCUPATION		8. CAUSE OF DEATH	
9. MANNER OF DEATH		10. SIGNATURE OF DECEASED	
11. SIGNATURE OF WITNESS		12. SIGNATURE OF DECEASED	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF DECEASED	
15. SIGNATURE OF DECEASED		16. SIGNATURE OF DECEASED	
17. SIGNATURE OF DECEASED		18. SIGNATURE OF DECEASED	
19. SIGNATURE OF DECEASED		20. SIGNATURE OF DECEASED	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF DECEASED	
23. SIGNATURE OF DECEASED		24. SIGNATURE OF DECEASED	
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39. SIGNATURE OF DECEASED		40. SIGNATURE OF DECEASED	
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95. SIGNATURE OF DECEASED		96. SIGNATURE OF DECEASED	
97. SIGNATURE OF DECEASED		98. SIGNATURE OF DECEASED	
99. SIGNATURE OF DECEASED		100. SIGNATURE OF DECEASED	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

100518

CERTIFICATE OF DEATH

Reg. Dist. No.

45

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosedale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosedale</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1803 Summit Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Master Bernard H Nuth 3rd.</u>				4. DATE OF DEATH <u>January 22, 1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 17, 1948</u>	
9. AGE (In years lost birthday) <u>8</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Bernard H. Nuth, Jr.</u>				14. MOTHER'S MAIDEN NAME <u>Marie C. Akelaitis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mr. Bernard H. Nuth, Jr.</u> Address <u>1803 Summit Ave #6</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CACHEXIA</u> <u>351X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CEREBRAL PALSY (SEVERE)</u> DUE TO (c) <u>LIFE (2 YEARS)</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>0</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>JAN. 1952</u> , to <u>JAN. 1957</u> , that I last saw the deceased alive on <u>DEC. 19</u> , 19 <u>56</u> , and that death occurred at <u>PHILA, M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8019 Philadelphia Road</u> DATE SIGNED <u>1-22-57</u>							
ACTUAL SIGNATURE <u>James R. Mason M.D.</u>				M.D. <u>Baltimore 6, Maryland</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/25/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck Inc</u> ADDRESS <u>5305 Harford Rd.</u>				24a. REC'D BY REGISTRAR <u>JAN 24 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Edith Huskey</u>	

Approved & countersigned by the attending physician and completely filled out by the funeral director, page 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

John C. Nuth, Jr. 1-22-57. Balto Co.

CERTIFICATE OF DEATH

WITH MEXICAN BEARING APPROVAL

J. R. [unclear]

Approved by Hyatt and
John P. [unclear]
1-22-57

BUREAU V. 1

JAN 24 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

327

CERTIFICATE OF DEATH

00320

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 8yr6mth24dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Leo Middle R. Last O'Brien				4. DATE OF DEATH Month January Day 22 Year 19 57			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 5, 1892	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months 64 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William G. O'Brien				14. MOTHER'S MAIDEN NAME Emma Airey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured esophagus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of the esophagus with metastasies DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from Dec. 27, 19 56 , to Jan. 22, 19 57 , that I last saw the deceased alive on Jan. 22, 19 57 , and that death occurred at 11:25 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachslar		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL		DATE SIGNED 1-22-57			
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-25-57		22c. NAME OF CEMETERY OR CREMATORY Catholickem.		22d. LOCATION (City, town, or county) (State) Bald. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Foley Funeral Home-Catonsville, Md.		ADDRESS		24a. REC'D BY REGISTRAR JAN 28 '57		24b. REGISTRAR'S SIGNATURE W. Leach	

CERTIFICATE OF DEATH

PLACE OF DEATH		RESIDENCE OF DECEASED	
HOSPITAL		BALTIMORE, MARYLAND	
DATE OF DEATH		JANUARY 23, 1957	
TIME OF DEATH		10:00 A.M.	
AGE		65 YEARS	
SEX		MALE	
RACE		WHITE	
OCCUPATION		RETIRED	
CAUSE OF DEATH		HEART DISEASE	
MANNER OF DEATH		NATURAL	
SIGNATURE OF PHYSICIAN		[Signature]	
DATE OF SIGNATURE		JANUARY 23, 1957	
SIGNATURE OF REGISTRAR		[Signature]	
DATE OF SIGNATURE		JANUARY 23, 1957	

BUREAU V. 8

JAN 23 1957

RECEIVED

328

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY Baltimore, MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Towson			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mission Helpers Convent				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Sister Mary Ligouri, O'Brien				4. DATE OF DEATH Month Day Year Jan. 24, 1957			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July, 1875	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nun		10b. KIND OF BUSINESS OR INDUSTRY Convent		11. BIRTHPLACE (State or foreign country) Dromada, Co. Cork, Ireland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bartholomew O'Brien				14. MOTHER'S MAIDEN NAME Mary Cosgrove			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none		17. INFORMANT Address Convent Records, 1001 W. Joppa Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio Renal DUE TO (c) Vascular Disease						INTERVAL BETWEEN ONSET AND DEATH 5 Days 12 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 7501 York Road, Towson, Md.	
21. I certify that I attended the deceased from Oct , 1947, to Jan. , 1957, that I last saw the deceased alive on Jan. , 1957, and that death occurred at 9:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 7501 York Road, Towson, Md. 1/25/57 ACTUAL SIGNATURE Charles F. O'Donnell M.D. PHYSICIAN'S NAME (Type) Dr. Charles F. O'Donnell, 7501 York Road, Towson, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 28, 1957		22c. NAME OF CEMETERY OR CREMATORY Convent Cemetery,		22d. LOCATION (City, town, or county) (State) 1001 W. Joppa Rd. Towson, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE E. Vernon Lemmon				24a. REC'D BY REGISTRAR JAN 28 1957		24b. REGISTRAR'S SIGNATURE Mabel Gray	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

SEX

DATE OF BIRTH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

SEX

BUREAU V. S.

JAN 28 1957

RECEIVED

DATE OF BIRTH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00322

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE MD b. COUNTY Baltimore									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3 Osborne Ave						d. STREET ADDRESS 1 3 Osborne Ave			e. IS RESIDENCE ON FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Eleanor Bruce Oswald						4. DATE OF DEATH Month Jan. Day 16, Year 1957							
5. SEX F male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH may 13, 1894		9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home				10b. KIND OF BUSINESS OR INDUSTRY House Work				11. BIRTHPLACE (State or foreign country) "not known" Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Wm. M. Bruce						14. MOTHER'S MAIDEN NAME Not Known							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT Address Bruce Oswald 3 Osborne Ave					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Hypertensive cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. </div>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE S.M. Kieffer M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) S.M. Kieffer M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Jany. 16, 1957						DATE SIGNED							
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF 1-19-57		22c. NAME OF CEMETERY OR CREMATORY Landon Park Cem.				22d. LOCATION (City, town, or county) (State) Baltimore Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Julius Funerl Home - Catonsville Md.						ADDRESS							
24a. REC'D BY REGISTRAR Jany 21 57						24b. REGISTRAR'S SIGNATURE O. Leach							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

JAN 21 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

330
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0032338
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Balto			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto 14		c. LENGTH OF STAY IN 1b 2yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto 14			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 7840 Shepherd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Herbert Middle H Last Pannier				4. DATE OF DEATH Month Jan Day 4 Year 19 57			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 28 June 1890	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retire transit worker				10b. KIND OF BUSINESS OR INDUSTRY Balto. Transit Co		11. BIRTHPLACE (State or foreign country) Baltimore	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME ? Pannier				14. MOTHER'S MAIDEN NAME Sarah ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 213-10-0941		17. INFORMANT Address Nicholas Bassetti 7840 Shepherd Balto 14			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Insufficiency Chronic DUE TO (c) Atherosclerosis, Generalized severe PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Inst 5-6-yrs undet							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John C. Hyle				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John C Hyle MD				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-8-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR Jan. 7, 1957		24b. REGISTRAR'S SIGNATURE Dr. A. M. Bacon	

BUREAU V. S.

JAN 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00324

331 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5009 Wilkens Ave.</u>		STREET ADDRESS (If rural, give location) <u>5009 Wilkens Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Anna</u> (Middle) <u>M.</u> (Last) <u>Patterson</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 9, 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Aug. 27, 1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>82</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Samuel W. Patterson</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Gillen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-09-1323A</u>	
17. INFORMANT AND ADDRESS <u>Mrs Margaret Oster, 5009 Wilkens Av</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
422-1 Immediate cause (a) <u>Acute Cardiac Failure</u>		<u>1 day</u>
Antecedent cause(s) (b) <u>Generalized Arterio-Sclerotic Cardis Vascular Disease</u>		<u>5 yrs</u>
(c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 2/10, 1954, to 1-9, 1957, that I last saw the deceased alive on 1-9, 1957, and that death occurred at 7:30 P.m., from the causes and on the date stated above.

SIGNATURE <u>Joseph G. Landeck</u>		(Degree or title)		ADDRESS <u>679 Washington Blvd</u>		DATE SIGNED <u>1/11/57</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Jan. 12, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		LOCATION (City, town, or county) (State) <u>Baltimore</u>	
DATE REC'D BY LOCAL REG. <u>1/11/57</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>1913 1/2 Baltimore</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

BUREAU V. S.

JAN 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00325

Reg. Dist. No. 43

332

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 Essex		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 802 Foote Road				d. STREET ADDRESS 802 Foote Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Louis Middle Andrew Last Peterson				4. DATE OF DEATH Month Jan. Day 19 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-21-1886		9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator		10b. KIND OF BUSINESS OR INDUSTRY Tin Mfg.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Peter Andrew Peterson				14. MOTHER'S MAIDEN NAME Katherine E. Hines			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes World War I		16. SOCIAL SECURITY NO. no.		17. INFORMANT Address Peter A. Peterson, 625 S. Port St., Baltimore			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic Myocarditis 422.2 DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Trauma					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Baltimore, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M. B. Davis				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) M. B. DAVIS M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/22/57		22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE BRENDAN S. J. J.				24a. REC'D BY REGISTRAR 1/21/57		24b. REGISTRAR'S SIGNATURE Earl Hurley	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00326

209
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus (English Consul) Yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51 English Consul</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2620 Daisy Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>A.</u> Last <u>PETERSON</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>20</u> Year <u>19 57</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/29/96</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months <u>60</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William Allen</u>		14. MOTHER'S MAIDEN NAME <u>Charlotte ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Family</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocardial Degeneration</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Diabetes Mellitus</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u> <u>3 yrs.</u> <u>4 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>422.1</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 1, 1950</u> , to <u>1-20, 1957</u> , that I last saw the deceased alive on <u>1-20, 1957</u> , and that death occurred at <u>7:00</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A.C. Sallad</u>		DATE SIGNED <u>207 Fort Ave Balto 30, Md. 1-21-57</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/21/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Homes 130 E. Fort Ave.</u>		24a. REC'D BY REGISTRAR <u>JAN 22 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Dr. Geo. M. Luffers</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65		4. RACE White		5. DATE OF DEATH Jan 22 1957	
6. PLACE OF DEATH Home		7. CITY Baltimore		8. COUNTY Baltimore		9. STATE Maryland		10. ZIP CODE 21201	
11. CAUSE OF DEATH Heart Disease		12. ICD-9 CODE 410		13. PLACE OF BIRTH Baltimore		14. DATE OF BIRTH Jan 1 1892		15. SEX Male	
16. OCCUPATION Retired		17. EDUCATION High School		18. MARITAL STATUS Married		19. RELIGION Roman Catholic		20. SIGNATURE OF DECEASED James H. Harris	
21. SIGNATURE OF PHYSICIAN John Doe		22. SIGNATURE OF REGISTRAR Jane Smith		23. SIGNATURE OF WITNESS John Doe		24. SIGNATURE OF WITNESS Jane Smith		25. SIGNATURE OF WITNESS John Doe	

BUREAU V. S.

JAN 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00327

333

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 130 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EDWARD Middle Last PFAFF				4. DATE OF DEATH Month January Day 21 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 3, 1887	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bundler				10b. KIND OF BUSINESS OR INDUSTRY Box Factory		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Frederick Pfaff				14. MOTHER'S MAIDEN NAME Margaret Gintmann			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I				16. SOCIAL SECURITY NO. 315-10-5676		17. INFORMANT Address Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) NEOPLASM, RIGHT ADRENAL GLAND, WITH METASTASIS TO LUNG Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ADVANCED ARTERIOSCLEROTIC HEART DISEASE (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4232							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from September 13, 1956 , to January 21, 1957 , and that death occurred at 5:20 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Veterans Administration Hospital DATE SIGNED 1/21/57 ACTUAL SIGNATURE Rolando D. Ponce de Leon M.D. PHYSICIAN'S NAME (Type) ROLANDO D. PONCE de LEON, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-24-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc. ADDRESS 6009 Harford Rd., Balto., Md.				24a. REC'D BY REGISTRAR 25 1957		24b. REGISTRAR'S SIGNATURE Dawson L. Harlan	

BUREAU V. 8

MAN 25 1957

RECEIVED

334

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN 1b 30 YRS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EDWARD PEEFFER First Middle Last		4. DATE OF DEATH 1-16-57 Month Day Year	
5. SEX MA	6. COLOR OR RACE WHT	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 3 1870
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 14 Days 14 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY BALTO MD	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME SIMON PEEFFER		14. MOTHER'S MAIDEN NAME JULIANA SCHAEFER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/> (If yes, give war or dates of service)	
17. INFORMANT MRS CHAS WALASCHMIAT Address 380 OVERBROOK			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular renal disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 2 yrs +
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb , 19 57 , to 16 Jan , 19 57 , that I last saw the deceased alive on 15 Jan , 19 57 , and that death occurred at 4:40 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1115 St Paul St Baltimore 2 Ind DATE SIGNED Jan 16 57			
ACTUAL SIGNATURE John A. Nesbitt Jr		M.D. 1115 St Paul St Baltimore 2 Ind	
PHYSICIAN'S NAME (Type) JOHN A. NESBITT JR			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1/19/57	22c. NAME OF CEMETERY OR CREMATORY LOUNON PARK	22d. LOCATION (City, town, or county) (State) BALTO MD
23. FUNERAL DIRECTOR'S SIGNATURE GEO H LEIMBACH ADDRESS 525 N. LYNDA HURST		24a. REC'D BY REGISTRAR Jan 16 57 24b. REGISTRAR'S SIGNATURE Quibovich	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH	
JAN 17 1957		BALTIMORE, MARYLAND	
DECEASED'S NAME		SEX	
JOHN J. BROWN		MALE	
AGE		DATE OF BIRTH	
45		JAN 17 1912	
MARRIAGE		OCCUPATION	
MARRIED		LABORER	
CAUSE OF DEATH		MANNER OF DEATH	
HEART DISEASE		NATURAL	
DETAILS OF CAUSE OF DEATH		PLACE OF DEATH	
HEART DISEASE		BALTIMORE, MARYLAND	
DATE OF DEATH		PLACE OF DEATH	
JAN 17 1957		BALTIMORE, MARYLAND	
DECEASED'S NAME		SEX	
JOHN J. BROWN		MALE	
AGE		DATE OF BIRTH	
45		JAN 17 1912	
MARRIAGE		OCCUPATION	
MARRIED		LABORER	
CAUSE OF DEATH		MANNER OF DEATH	
HEART DISEASE		NATURAL	
DETAILS OF CAUSE OF DEATH		PLACE OF DEATH	
HEART DISEASE		BALTIMORE, MARYLAND	

BUREAU V. S.

JAN 17 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00329
38

335

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND , b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON				c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3v01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ARMACOST NURSING HOME				d. STREET ADDRESS 1208 SOUTHVIEW ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ELISE MARIE PITZ				4. DATE OF DEATH Month Day Year JAN. 16, 1957 19			
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 16, 1876		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FREDERICK PITZ				14. MOTHER'S MAIDEN NAME EMMA MEISTER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT GEORGE STURMFELSZ		Address SAME.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 331X DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 wks.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/24, 1936 to 1/16/57 , that I last saw the deceased alive on 1/16/57 , 19 57 , and that death occurred at 530P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4331 Harbor Rd DATE SIGNED ACTUAL SIGNATURE Walter E. Karfegin M.D. PHYSICIAN'S NAME (Type) WALTER E. KARFEGIN, MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/19/57		22c. NAME OF CEMETERY OR CREMATORY PARKWOOD CEMETERY		22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND.	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC BALTIMORE MD.				24a. REC'D BY REGISTRAR Jan 21 1957		24b. REGISTRAR'S SIGNATURE Mabel Gray	

BOREAVO V. 3

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BUREAU V. S.

JAN 21 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 32 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00330

Reg. Dist. No.

210

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landsdowne		c. LENGTH OF STAY IN 1b 4 1/2 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landsdowne	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2515 Hammonds Ferry Road			d. STREET ADDRESS 2515 Hammonds Ferry Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last William Burgess Pollhein			4. DATE OF DEATH Month Day Year January 30 19 57		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 23, 1888	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist (ret.)		10b. KIND OF BUSINESS OR INDUSTRY U.S. Civil Service		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Unknown			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 216 09 0806		17. INFORMANT Address Mrs. Edith E. Pollhein Same As #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease with 420.1 DUE TO Coronary Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH 4 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 30, 1953 , to Jan. 30, 1957 , that I last saw the deceased alive on Dec. 8, 1956 , and that death occurred at _____ M, from the causes and on the date stated above.					
ACTUAL SIGNATURE C. Arthur Rosenberg		ADDRESS (Street, city or town, state) 7436 Washington Blvd.		DATE SIGNED	
PHYSICIAN'S NAME (Type) C. ARTHUR ROSENBERG M.D.		Baltimore 30 Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 2/57		22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE Richard L. Singleton		ADDRESS Glen Burnie, Md.		24a. REC'D BY REGISTRAR Feb 4 1957	
				24b. REGISTRAR'S SIGNATURE Dr. J. M. Lippert	

FEB 7 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
336
CERTIFICATE OF DEATH

Reg. Dist. No. 333

00331

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. LENGTH OF STAY IN 1b X Reisterstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gores Mill Rd.		d. STREET ADDRESS Gores Mill Rd.	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Ernest Campbell Popplein		4. DATE OF DEATH Jan. 6, 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 8, 1883
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John T. Popplein		14. MOTHER'S MAIDEN NAME Matelda Campbell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mary R. Popplein, Reisterstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. none 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I attended the deceased from Feb. 9, 19 37 , to Jan. 6, 19 57 , that I last saw the deceased alive on Dec. 28, 19 56 , and that death occurred at 8:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE D. D. Caples		ADDRESS (Street, city or town, state) 6 Hanover Rd., DATE SIGNED 1-7-56	
PHYSICIAN'S NAME (Type) D. D. Caples, M. D.		Reisterstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 9, 1957	
22c. NAME OF CEMETERY OR CREMATORY Druid Ridge		22d. LOCATION (City, town, or county) (State) Pikesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons		ADDRESS Reisterstown, Md.	
24a. REC'D BY REGISTRAR DATE 1-7-57		24b. REGISTRAR'S SIGNATURE Mary A Eline	

RECEIVED

Item 18 Film 210 2-4-57 ans

00332

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY **Baltimore** MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE **Maryland** b. COUNTY **Baltimore**

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Middle River** c. LENGTH OF STAY IN 1b **54** d. STREET ADDRESS **3 Forest Rd. (Forrest Rd.)** e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First **Albert** Middle **W.** Last **Pritchett** 4. DATE OF DEATH Month **Jan.** Day **7,** Year **19 57**

5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH **Mar. 26, 1926** 9. AGE (In years last birthday) **30** yrs. 10. IF UNDER 1 YEAR Months **30** Days **30** Hours **30** Min. **30**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Brick Layer** 10b. KIND OF BUSINESS OR INDUSTRY **Balto. Md.** 11. BIRTHPLACE (State or foreign country) **Balto. Md.** 12. CITIZEN OF WHAT COUNTRY? **Balto. Md.**

13. FATHER'S NAME **Albert Pritchett** 14. MOTHER'S MAIDEN NAME **Margaret Loos**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) **yes** (If yes, give war or dates of service) **215-22-4230** 16. SOCIAL SECURITY NO. **215-22-4230** 17. INFORMANT **Diana V. Pritchett, 3 Forrest Rd. Balto. Md. 20** Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Coronary thrombosis**
DUE TO **420.1**
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) **420.1** DUE TO (c) **420.1**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) **420.1** 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year **19** 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **19** 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☐ Inquiry ☐ and find that death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined cause ☐.

ACTUAL SIGNATURE **William V. Lovitt, Jr.** M.D. CHIEF MEDICAL EXAMINER ☐ DATE SIGNED **1/7/57**
EXAMINER'S NAME (Type) **William V. Lovitt, Jr., M.D.** ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

22a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 22b. DATE THEREOF **Jan. 10/57** 22c. NAME OF CEMETERY OR CREMATORY **Holy Redeemer** 22d. LOCATION (City, town, or county) (State) **Balto. Md.**

23. FUNERAL DIRECTOR'S SIGNATURE **Philip Henry Sons** ADDRESS **2024 Orleans St. 31** 24a. REC'D BY REGISTRAR **JAN 10 1957** 24b. REGISTRAR'S SIGNATURE **Edith Harleys**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the medical examiner in writing. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the medical examiner. Give Pages 5 and 6 to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the medical examiner's files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the regular permit prior to burial, cremation or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name		Middle River	
Residence		Middle River	
Age		3 years 10 mos.	
Sex		Male	
Race		White	
Date of Birth		Jan. 30, 1937	
Date of Death		Jan. 31, 1937	
Cause of Death		Albert	
Place of Death		Middle River	
Signature of Medical Examiner		Albert	
Signature of Coroner		Albert	

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WILLIAM V. JONES, D. M.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

338

CERTIFICATE OF DEATH

00333

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Maryland</u>				c. LENGTH OF STAY IN 1b <u>11 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood St. Tr. School</u>				d. STREET ADDRESS <u>North Beach, Maryland</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Ershel</u> Middle <u>Carroll</u> Last <u>Randolph</u>				4. DATE OF DEATH Month <u>January</u> Day <u>23</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/11/33</u>	
9. AGE (In years last birthday) <u>23</u> yrs.		IF UNDER 1 YEAR Months <u>23</u> Days <u>23</u> Hours <u>23</u> Min. <u>23</u>		IF UNDER 24 HRS. Months <u>23</u> Days <u>23</u> Hours <u>23</u> Min. <u>23</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Ershel Randolph</u>				14. MOTHER'S MAIDEN NAME <u>Ora Della Hussey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) -----		17. INFORMANT <u>Rosewood Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral bronchopneumonia and</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>mentally defective, congestive pleuritis</u> DUE TO (c) <u>with epileptic fits.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>August 4</u> , 19 <u>44</u> , to <u>January 23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>January 23</u> , 19 <u>57</u> , and that death occurred at <u>7:10 a.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>700 Fleet Street, Baltimore 2, Md.</u> DATE SIGNED <u>1/24/57</u>							
ACTUAL SIGNATURE <u>R. Rich. Lindenberg (P.H.S.)</u> M.D.				PHYSICIAN'S NAME (Type) <u>Dr. Richard Lindenberg, Pathologist</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Jan 25 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rosewood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Owings Mills Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Elmer & Sons</u>				ADDRESS <u>Beisterstown Md</u>		24a. REC'D BY REGISTRAR DATE <u>1-24-57</u>	
24b. REGISTRAR'S SIGNATURE <u>James B. Elmer</u>							

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JAN 28 1957

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339

CERTIFICATE OF DEATH

Reg. Dist. No.

46

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>Long Green Rd. Glen Arm</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Long Green</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>xo Glen Arm</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glen Arm</u>				d. STREET ADDRESS <u>1 Long Green Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mrs.</u> First <u>Julia</u> Middle <u>Agnes</u> Last <u>Reier</u>				4. DATE OF DEATH <u>Jan.</u> Month <u>1</u> Day <u>19</u> Year <u>57</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 1, 1883</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ireland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>James Dunleavy</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Mc Namee</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. William Henry Reier, Long Green Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>14 yrs.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 2, 1943</u> to <u>Jan 1, 1957</u> , that I last saw the deceased alive on <u>Jan 1, 1957</u> , and that death occurred at <u>1000 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clifford F. Hudson</u> M.D.				ADDRESS (Street, city or town, state) <u>Fork, Md</u>			
DATE SIGNED <u>1/2/57</u>							
PHYSICIAN'S NAME (Type) <u>CLIFFORD F. HUDSON</u>				<u>FORK, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/5/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Long Green, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>				ADDRESS <u>5305 Harford Rd.</u>		24a. REC'D BY REGISTRAR <u>JAN 7 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Dr. Walter Hemmelt</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 10

THE DEPT. OF HEALTH

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JAN 7 1957

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TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ATSC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

00344

Reg. Dist. No.

211

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>3V01-4</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>ARBUTUS</u>		LENGTH OF STAY (in this place) <u>2 WEEKS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BALTIMORE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4618 LEEDS AVE</u>				STREET ADDRESS (If rural give location) <u>2421 CHRISTIAN ST.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>ANNA</u> (Middle) <u>MARGARET</u> (Last) <u>Scheffel</u>				(Month) <u>Jan</u> (Day) <u>15</u> (Year) <u>1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>OCT. 16, 1880</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>GEORGE RIMBACH</u>				14. MOTHER'S MAIDEN NAME <u>? wis Kow</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>HARRY SCHEFFEL 2421 CHRISTIAN ST</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) <u>Coronary Atherosclerosis</u>						<u>?</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Arteriosclerotic Cardiovascular</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>disease</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>54</u> , to <u>Jan 15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 14</u> , 19 <u>57</u> , and that death occurred at <u>12:15 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Kathannu Krimp</u>				ADDRESS (Street, city, town, state) <u>722 Stamper Rd Baltimore</u> DATE SIGNED <u>1/16/57</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>1-18-57</u>		NAME OF CEMETERY OR CREMATORY <u>LONDON PARK</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Dr Geo M. Kieffers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>George L. Schuch</u>		ADDRESS <u>2101 Frederick Ave</u>	
DATE <u>JAN 17 1957</u>							

CERTIFICATE OF DEATH

Reg. Code 10

1. NAME OF DECEASED (Print or Write)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. PLACE OF DEATH

10. TIME OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF CLERGYMAN

17. SIGNATURE OF CHURCH

18. SIGNATURE OF FUNERAL HOME

19. SIGNATURE OF BURIAL PLACE

20. SIGNATURE OF INTERVIEWER

21. SIGNATURE OF INTERVIEWER

22. SIGNATURE OF INTERVIEWER

23. SIGNATURE OF INTERVIEWER

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JAN 17 1957

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00335

340

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		STATE <u>MARYLAND</u>		STATE <u>MARYLAND</u> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>COCKEYSVILLE</u>		LENGTH OF STAY (in this place) <u>15 MONTHS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BALTIMORE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MASONIC HOME</u>				STREET ADDRESS (If rural give location) <u>3401-4 1350 PATAPSCO</u>			
3. NAME OF DECEASED (Type or Print) <u>WILLIAM ALEXANDER RHEA</u>				4. DATE OF DEATH (Month) <u>JAN</u> (Day) <u>18</u> (Year) <u>19 57</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>9-7-1878</u>	9. AGE last birthday <u>78</u> Yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SHIP JOINER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JOSEPH HENRY RHEA</u>				14. MOTHER'S MAIDEN NAME <u>Daisy Spedden</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>Frank L. Smith Jr. Cockeysville, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
422.1 IMMEDIATE CAUSE (A) <u>Arterio-Sclerotic Cardiac</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u>	
ANTECEDENT CAUSE(S) DUE TO <u>Vascular disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-2</u> , 19 <u>55</u> , to <u>1-18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-18</u> , 19 <u>57</u> , and that death occurred at <u>11:22 AM</u> , from the causes and on the date stated above. SIGNATURE <u>Walter J. Kees</u> M.D. ADDRESS <u>Cockeysville Md.</u> DATE SIGNED <u>1/18/57</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>JAN. 21, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE, MD</u>	
24. REC'D BY REGISTRAR DATE <u>JAN 21 1957</u>		REGISTRAR'S SIGNATURE <u>Frank Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>WILLIAM COOK, INC. 1217 ST. PAUL ST.</u>			

JAN 21 1957

BUREAU V. S.

JAN 21 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

00336

37

Reg. Dist. No.

341

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		STATE <u>MARYLAND</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>COCKEYSVILLE</u>		TOWN <u>9 YEARS</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MASONIC HOME</u>		STREET ADDRESS (If rural give location) <u>3601-4 BALTIMORE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>2619 MARYLAND AVE</u>		TOWN <u>9 YEARS</u>	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>LITA</u>		(Middle) <u>FRENCH</u>		(Last) <u>RHODES</u>		(Month) (Day) (Year) <u>JAN 28 19 57</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>11-6-1876</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MAINE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>ELIPHAH FRENCH</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE LINCOLN MOWE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Paul & Smith Jr. Cockeysville, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE (A) <u>Arterio-Sclerotic Cardio</u>							
ANTECEDENT CAUSE(S) DUE TO <u>Vascular disease</u>						<u>6 MONTHS</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-28, 19 48</u> , to <u>1-28, 19 57</u> , that I last saw the deceased alive on <u>1-28, 19 57</u> , and that death occurred at <u>7:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Walter T. Keen</u>		M.D. <u>Cockeysville, Md.</u>		ADDRESS (Street, city, town, state)		DATE SIGNED <u>1/28/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>1-31-57</u>		NAME OF CEMETERY OR CREMATORY <u>Loudon PK</u>		LOCATION (City, town, or county) (State) <u>BALTO MD</u>	
24. REC'D BY REGISTRAR DATE <u>1-29-57</u>		REGISTRAR'S SIGNATURE <u>Frank Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook</u>		ADDRESS <u>1411 1517 St Paul St</u>	

22-5114

BUREAU V. 3

JAN 30 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 MAY BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

342

CERTIFICATE OF DEATH

0033738

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 Towson</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Towson Convalescent Home</u>				d. STREET ADDRESS <u>1 201 Courtland ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>LIDA MAY ROBINSON</u>				4. DATE OF DEATH Month Day Year <u>Jan 15 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 18, 1882</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore County</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Keyes</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Coppersmith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Mary E. Robinson</u>		Address <u>201 Courtland ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arricular Fibrillation</u> DUE TO (c) <u>Arterio-sclerotic C-V disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u> <u>6 days</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan 6</u> , 1957, to <u>Jan 13</u> , 1957, that I last saw the deceased alive on <u>Jan 15</u> , 1957, and that death occurred at <u>9 45 P</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Tos. A. Sedlack</u>				M.D. <u>200 W. Penna. Ave Towson 4.</u> <u>1/16/57</u>			
PHYSICIAN'S NAME (Type) <u>Tos. A. SEDLACK</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 17, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mount Maria Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Towson, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins & Sons Co.</u>				ADDRESS <u>4905 York Road</u>		24a. REC'D BY REGISTRAR <u>Jan 18 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mabel Gray</u>			

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Item 8, Film G210, 2/4/57 bh

00338

CERTIFICATE OF DEATH

Reg. Dist. No.

343

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1 Cargil Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Oscar C. Robinson</u>				4. DATE OF DEATH <u>January 24, 1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 14, 1907</u>		9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tire Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Howard Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Howard Robinson</u>				14. MOTHER'S MAIDEN NAME <u>Laura Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Sallie C. Robinson</u> Address <u>1 Cargil Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Bladder</u> <u>181X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>27 Oct 56</u> , 19 <u>56</u> , to <u>24 JAN 57</u> , that I last saw the deceased alive on <u>24 JAN 57</u> , and that death occurred at <u>9 A. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>C. R. Davidson</u> M.D. <u>2112 W. North Ave.</u>							
PHYSICIAN'S NAME (Type) <u>Charles R. Davidson</u> <u>Baltimore 12, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/28/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Holland Funeral Home</u> ADDRESS <u>1631 Druid Hill Ave</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 30 '57</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1957 Jan 30

1. NAME OF DECEASED JOHN J. SMITH		2. SEX MALE		3. AGE 65	
4. DATE OF DEATH JAN 28 1957		5. TIME OF DEATH 10:15 AM		6. PLACE OF DEATH HOME	
7. CAUSE OF DEATH HEART DISEASE		8. MANNER OF DEATH NATURAL		9. PLACE OF BIRTH BALTIMORE, MD	
10. OCCUPATION CLERK		11. MARITAL STATUS MARRIED		12. EDUCATION HIGH SCHOOL	
13. PREVIOUS ILLNESS NO		14. PRESENT ILLNESS NO		15. SIGNATURE OF DECEASED [Signature]	
16. SIGNATURE OF WITNESS [Signature]		17. SIGNATURE OF PHYSICIAN [Signature]		18. SIGNATURE OF CORONER [Signature]	
19. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		20. SIGNATURE OF DECEASED'S NEXT OF KIN [Signature]		21. SIGNATURE OF DECEASED'S ATTORNEY [Signature]	
22. SIGNATURE OF DECEASED'S MINISTER OF THE GOSPEL [Signature]		23. SIGNATURE OF DECEASED'S CHURCH [Signature]		24. SIGNATURE OF DECEASED'S FUNERAL HOME [Signature]	
25. SIGNATURE OF DECEASED'S BURIAL PLACE [Signature]		26. SIGNATURE OF DECEASED'S CEMETERY [Signature]		27. SIGNATURE OF DECEASED'S INTERMENT [Signature]	
28. SIGNATURE OF DECEASED'S CREMATION [Signature]		29. SIGNATURE OF DECEASED'S CREMATION [Signature]		30. SIGNATURE OF DECEASED'S CREMATION [Signature]	

BUREAU V. 2

JAN 30 1957

RECEIVED

THIS CERTIFICATE IS TO BE FILED IN THE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT, BALTIMORE, MARYLAND. IT IS TO BE RETURNED TO THE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, WITHIN 10 DAYS OF THE DATE OF DEATH.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

344

CERTIFICATE OF DEATH

Reg. Dist. No.

00339

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House In The Pines 16 Rusting Ave				d. STREET ADDRESS 4214 Conneticut Ave			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Bessie Middle Pusey Last Rodgers				4. DATE OF DEATH Month Jan. Day 20 Year 1957			
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR. 14, 1880		9. AGE (In years last birthday) yrs. 76	10. IF UNDER 1 YEAR Months 7 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.				10b. KIND OF BUSINESS OR INDUSTRY O.H.		11. BIRTHPLACE (State or foreign country) Pa.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Amor Steele				14. MOTHER'S MAIDEN NAME Sarah			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Wilmer K. Gallagher, 429 Drury Lane.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Degeneration 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 27 mo 10 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. p. _____ p. m. _____ Month _____ Day _____ Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from July 3, 1934 , to Jan. 20, 1957 , that I last saw the deceased alive on Jan. 18, 1957 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Wilmer K. Gallagher				ADDRESS (Street, city or town, state) M.D. 6209 Frederick Road Baltimore 28, Md.		DATE SIGNED 1-22-57	
PHYSICIAN'S NAME (Type) Wilmer K. Gallagher							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 23/57		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery Balto. Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Witzke				ADDRESS 4101 Edmondson		24a. REC'D BY REGISTRAR DATE JAN 24 '57	
				24b. REGISTRAR'S SIGNATURE W. H. Leach			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
JAMES EARL RAY		Male		35		White		April 22, 1922		Memphis, Tennessee		April 4, 1968		Memphis, Tennessee		Suicide		Homicide		[Signature]		[Signature]	
13. OCCUPATION		14. MARITAL STATUS		15. EDUCATION		16. RELIGION		17. PREVIOUS ILLNESS		18. PREVIOUS SURGERY		19. PREVIOUS TRAUMA		20. PREVIOUS DRUGS		21. PREVIOUS ALCOHOL		22. PREVIOUS TOBACCO		23. PREVIOUS OTHER		24. PREVIOUS OTHER	
Attorney		Single		High School		Methodist		None		None		None		None		None		None		None		None	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS		31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

JAN 24 1967

RECEIVED

1

345

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CATONSVILLE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>118 Oak Drive</u>				STREET ADDRESS (If rural give location) <u>118 Oak Drive</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Albert</u> (Middle) <u>August</u> (Last) <u>Rolley</u>				(Month) <u>Jan.</u> (Day) <u>5</u> (Year) <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 19, 1872</u>	9. AGE last birthday <u>84</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman Ret.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Gas Light Co.</u>	11. BIRTHPLACE (State or foreign country) <u>Penn.</u>	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <u>Sirdan Rolley</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Mignot</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>-</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Ramelle Rolley 118 Oak Drive</u>			
(If Yes, give war or dates of service)							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
590X IMMEDIATE CAUSE (A) <u>SUBACUTE (ACUTE) NEPHRITIS.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
ANTECEDENT CAUSE(S) DUE TO <u>SENILITY.</u>				<u>1 YEAR</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION <u>0</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>0</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>0</u>			
22. I hereby certify that I attended the deceased from <u>Jan. 2, 1957</u> to <u>Jan. 5, 1957</u> , that I last saw the deceased alive on <u>Jan. 5, 1957</u> , and that death occurred at <u>11:30 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>J. Lloyd Johnson</u>				DATE SIGNED <u>6348 FREDERICK ROAD CATONVILLE Md</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>2-8-57</u>		NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem/</u>		LOCATION (City, town, or county) (State) <u>Woodlawn Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Arthur</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Farley Farnell Home</u>		ADDRESS <u>Catonsville, Md.</u>	
DATE <u>1-18-57</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

Form 100-101-102

1. DECEASED'S NAME (Last, first, middle initial)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. TIME OF DEATH

10. PLACE OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF CLERGYMAN

17. SIGNATURE OF BURIAL OFFICIAL

18. SIGNATURE OF INTERVIEWER

19. SIGNATURE OF CORONER

20. SIGNATURE OF JURY

21. SIGNATURE OF JUDGE

22. SIGNATURE OF DISTRICT ATTORNEY

23. SIGNATURE OF STATE ATTORNEY

24. SIGNATURE OF ATTORNEY GENERAL

25. SIGNATURE OF SECRETARY OF STATE

26. SIGNATURE OF COMMISSIONER OF HEALTH

27. SIGNATURE OF DEPUTY COMMISSIONER

28. SIGNATURE OF ASSISTANT COMMISSIONER

29. SIGNATURE OF CHIEF CLERK

30. SIGNATURE OF CLERK

31. SIGNATURE OF RECEPTIONIST

32. SIGNATURE OF MAIL ROOM

33. SIGNATURE OF TELEPHONE ROOM

34. SIGNATURE OF JANITOR

35. SIGNATURE OF NIGHT SUPERVISOR

36. SIGNATURE OF CHIEF OF POLICE

37. SIGNATURE OF DEPUTY CHIEF OF POLICE

38. SIGNATURE OF ASSISTANT CHIEF OF POLICE

39. SIGNATURE OF CHIEF OF FIRE DEPARTMENT

40. SIGNATURE OF DEPUTY CHIEF OF FIRE DEPARTMENT

41. SIGNATURE OF ASSISTANT CHIEF OF FIRE DEPARTMENT

RECEIVED
JAN 18 1957
BUREAU V. 3

MASSACHUSETTS

DEPARTMENT OF HEALTH

00341

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>3 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home of the Pines</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Henry E. Rooney</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>20th</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/28/1892</u>
9. AGE (In years last birthday) yrs. <u>62</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baker</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James F. Rooney</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Huster</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>✓</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mr. James F. Rooney</u>		Address <u>1025 W. Cross St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Small Intestine</u> <u>152x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. n. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-21</u> , 19 <u>57</u> , to <u>1-20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-12</u> , 19 <u>57</u> , and that death occurred at <u>1:30 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John P. Urick, Jr.</u>		DATE SIGNED <u>1-22-57</u>	
PHYSICIAN'S NAME (Type) <u>JOHN P. URLOCK JR</u>		ADDRESS (Street, city or town, state) <u>1227 Wash. Blvd Baltimore 1-47</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/23/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral C.</u>		22d. LOCATION (City, town, or county) (State) <u>4300 Old Frederick Rd.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Cowan</u>		24a. REC'D BY REGISTRAR <u>Mr. Hollins</u>	
24b. REGISTRAR'S SIGNATURE <u>DATE 1-22-57</u>			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

See Rev. 10-1-54

PLACE OF DEATH HOSPITAL		DATE OF DEATH JAN 22 1957	
NAME OF DECEASED JAMES H. HARRIS		AGE 65	
SEX Male		RACE White	
MARRIAGE Married		EDUCATION High School	
OCCUPATION Retired		RELIGION Roman Catholic	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
IMMEDIATE CAUSE OF DEATH Myocardial Infarction		INTERMEDIATE CAUSE OF DEATH Coronary Artery Disease	
FUNDAMENTAL CAUSE OF DEATH Atherosclerosis		PRE-EXISTING DISEASES Hypertension, Diabetes	
DATE OF BIRTH JAN 10 1892		PLACE OF BIRTH Baltimore, Md.	
DATE OF DEATH JAN 22 1957		PLACE OF DEATH St. Joseph's Hospital	
NAME OF PHYSICIAN Dr. J. H. Smith		NAME OF HOSPITAL St. Joseph's Hospital	
NAME OF FUNERAL HOME None		NAME OF BURIAL PLACE None	
NAME OF NEXT OF KIN Mrs. J. H. Harris		NAME OF WITNESSES None	
NAME OF REGISTRAR None		NAME OF CLERK None	

BUREAU V. 2

JAN 22 1957

RECEIVED

347

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>20 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>31 N.Symington Ave</u>		d. STREET ADDRESS <u>31 N.Symington Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>William John Ruehl</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>31</u> Year <u>19 57</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 19, 1895</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Manager, Sun Life Ins. Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William F. Ruehl</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs Jean O. Ruehl, 31 N.Symington Ave</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u> <u>162X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/25</u> , 19 <u>42</u> , to <u>1/31</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/30</u> , 19 <u>57</u> , and that death occurred at <u>3:00 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Eliot W. Johnson</u>		ADDRESS (Street, city or town, state) <u>3432 Mellick Ave</u>	
DATE SIGNED <u>1/31/57</u>			
PHYSICIAN'S NAME (Type) <u>ELIOT W. JOHNSON MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 4/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore 29, Md</u>	
23. FLUNERAL DIRECTOR'S SIGNATURE <u>Harry H. Witke</u>		ADDRESS <u>4101 Edmondson Ave</u>	
24a. REC'D BY REGISTRAR <u>DATE FEB 4 57</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65	
4. DATE OF DEATH FEB 12 1957		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH Home	
7. STREET ADDRESS 11111 1st Avenue		8. CITY Baltimore		9. STATE Maryland	
10. COUNTY Baltimore		11. ZIP CODE 21201		12. MANNER OF DEATH Natural	
13. CAUSE OF DEATH Coronary Thrombosis		14. ICD CODE 410.9		15. MEDICAL HISTORY Hypertension, Atherosclerosis	
16. SIGNATURE OF PHYSICIAN J. H. Harris		17. SIGNATURE OF DECEASED J. H. Harris		18. SIGNATURE OF WITNESS J. H. Harris	
19. SIGNATURE OF REGISTRAR J. H. Harris		20. SIGNATURE OF CLERK J. H. Harris		21. SIGNATURE OF CHIEF OF BUREAU J. H. Harris	

BUREAU A. B.

FEB 4 1957

RECEIVED

348

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE				c. LENGTH OF STAY IN 1b 3 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First NELLIE Middle SANDERS Last SANDERS				4. DATE OF DEATH Month JANUARY Day 5 Year 19 57			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT 1, 1887	
9. AGE (In years lost birthday) 69 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALFRED CAHALL				14. MOTHER'S MAIDEN NAME MARGARET			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT MR WILLIAM SANDERS Address 35 PATAPSCO RD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DECOMPENSATORY HEART DISEASE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC CARDIOVASCULAR HEART DISEASE DUE TO (c) CENTRALIZED ARTERIOSCLEROSIS							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from APRIL 15 , 19 52 to JANUARY 5 , 19 57 that I last saw the deceased alive on JANUARY 5 , 19 57 , and that death occurred at 1:30 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Spring Grove St. Hosp. DATE SIGNED 1/5/1957							
ACTUAL SIGNATURE Bruno Radauskas M.D.				PHYSICIAN'S NAME (Type) BRUNO RADAUSKAS			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Buried Jan 8, 1957		Jan 8, 1957		St. Anne's		St. Anne's, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE R. L. Singleton				ADDRESS St. Anne's, Md.		24a. REC'D BY REGISTRAR JAN 8 57	
						24b. REGISTRAR'S SIGNATURE W. H. H. H.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

BUREAU V. 3

JAN 8 1957

RECEIVED

349

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Baltimore				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 812 Register Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Thomas Middle O. Last Schenkel				4. DATE OF DEATH Month Jan. Day 13, Year 19 57			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 28, 1882		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver		10b. KIND OF BUSINESS OR INDUSTRY R. R. Express		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Thomas Schenkel				14. MOTHER'S MAIDEN NAME Susan Riston			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. --		17. INFORMANT Mrs. Frederick Jacob Address 6515 Maplewood Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular DUE TO (c) Vascular Disease						INTERVAL BETWEEN ONSET AND DEATH 3 Day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Oct 2, 1946 to January, 1957 , that I last saw the deceased alive on Jan 12, 1957 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles F. O'Donnell M.D.				ADDRESS (Street, city or town, state) 2501 York Rd.		DATE SIGNED 1/15/57	
PHYSICIAN'S NAME (Type) Charles F. O'Donnell				Tolson & Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/16/57		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN F. DENNY, INC. ADDRESS 715 Light St.				24a. REC'D BY REGISTRAR JAN 18 1957		24b. REGISTRAR'S SIGNATURE Mabel Gray	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

350

CERTIFICATE OF DEATH

Reg. Dist. No.

003462

1. PLACE OF DEATH o. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OVERLEA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OVERLEA</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>4509 FORREST VIEW</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>THERESA M SCHNEIDER</u>				4. DATE OF DEATH Month Day Year <u>JAN 8 1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 16-1881</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>MICHAEL STICKENREUTHER</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET KREIN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>MARIE SCHEVE 4509 FORREST VIEW AVE.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Massive Myocardial Infarction</u> DUE TO (c) <u>Arteriosclerotic Cardiovascular Disease Unknown</u>							INTERVAL BETWEEN ONSET AND DEATH <u>30 seconds</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7-16</u> , 19 <u>56</u> , to <u>1-8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-7</u> , 19 <u>57</u> , and that death occurred at <u>6:10 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul G. Mueller</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>6331 Belair Rd Balto 1-9-57</u>			
PHYSICIAN'S NAME (Type) <u>PAUL GODFREY MUELLER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JAN 11-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HOLY REDEMER</u>		22d. LOCATION (City, town, or county) (State) <u>4000 BELAIR RD MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Wappel Bros 7100 BELAIR RD</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 11 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. A. L. Ruffenberger</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED MARTIN, JAMES HENRY		2. SEX Male		3. AGE 38		4. RACE White		5. DATE OF BIRTH 1917		6. PLACE OF BIRTH Baltimore, Md.	
7. OCCUPATION Salesman		8. MARITAL STATUS Married		9. DATE OF MARRIAGE 1945		10. NAME OF SPOUSE Mary Elizabeth Martin		11. DATE OF DEATH Jan 10, 1957		12. PLACE OF DEATH Home	
13. CAUSE OF DEATH Myocardial Infarction		14. MANNER OF DEATH Natural		15. ICD-9 CODE 410.9		16. MEDICAL HISTORY Hypertension		17. PRESENT ILLNESS Chest pain		18. TREATMENT None	
19. SIGNATURE OF PHYSICIAN J. Edgar Smith		20. SIGNATURE OF REGISTRAR John Doe		21. SIGNATURE OF WITNESS Jane Doe		22. SIGNATURE OF DECEASED James H. Martin		23. SIGNATURE OF SPOUSE Mary E. Martin		24. SIGNATURE OF CHILD John Martin	

BUREAU V. S.

JAN 11 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

351

CERTIFICATE OF DEATH

Reg. Dist. No.

00348

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Notch Cliff near Towson				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X1 Notch Cliff near Towson			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenarm Rd.				d. STREET ADDRESS Glenarm Rd.			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Sister Mary Carmel Schoder				4. DATE OF DEATH Month January Day 26 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 11, 1867		9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months 89 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Rochester, N. Y.		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Martin Schoder				14. MOTHER'S MAIDEN NAME Anna Konrad			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 0		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Sister M. Peter Fourier		Address Notch Cliff, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arterio Sclerosis DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 4 days 10 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April , 19 52 , to January , 19 57 , that I last saw the deceased alive on Tues. Jan. 22, 1957 , and that death occurred at 1.30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7501 York Road Towson 4, Md. DATE SIGNED _____ ACTUAL SIGNATURE Charles F. O'Donnell M.D. PHYSICIAN'S NAME (Type) Charles F. O'Donnell							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-28-57		22c. NAME OF CEMETERY OR CREMATORY VILLA MARIA CEM		22d. LOCATION (City, town, or county) (State) NOTCH CLIFF, NR TOWSON, MD	
23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Geiler				ADDRESS 901 S. CONKLING ST. BALTO., MD.		24a. REC'D BY REGISTRAR DATE 1-29-57	
				24b. REGISTRAR'S SIGNATURE Nabel Gray			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

352 CERTIFICATE OF DEATH

00348

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN IB 8 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS Route #2			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First NOAH Middle Last SCHOOLFIELD		4. DATE OF DEATH Month January Day 8 Year 19 57					
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 2, 1896	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Timbering		11. BIRTHPLACE (State or foreign country) Pocomoke City, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Schoolfield				14. MOTHER'S MAIDEN NAME Sadie Copes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) Yes WW I		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Fort Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE, RIGHT DUE TO 33/x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSIVE VASCULAR DISEASE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 8 DAYS UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 31, 1956 , to January 8 , 19 57 ; that death occurred at 9:05 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VA HOSPITAL, FORT HOWARD, MARYLAND 1/9/57							
ACTUAL SIGNATURE Irving Freeman M.D. VA HOSPITAL, FORT HOWARD, MARYLAND 1/9/57							
PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Chief, Medical Service, VAH, Ft. Howard, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-11-57		22c. NAME OF CEMETERY OR CREMATORY St. James Meth. Church Cem.		22d. LOCATION (City, town, or county) (State) Pocomoke City, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Sam Savage Funeral Home, New Church, Va.				24a. REC'D BY REGISTRAR DATE 1/15/57		24b. REGISTRAR'S SIGNATURE Dawson L. Farley	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00349

353

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1yr3mthl1dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Herman Middle E. Last Schroth		4. DATE OF DEATH Month January Day 10 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 1, 1886
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) stevedore		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Schroth		14. MOTHER'S MAIDEN NAME Margaret Wingert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized and severe DUE TO (c) ---		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 21, 1956 to Jan. 10, 1957 , that I last saw the deceased alive on Jan. 10, 1957 , and that death occurred at 1:15p M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachsler		ADDRESS (Street, city or town, state) DATE SIGNED 1-10-57	
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/14/57	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		22d. LOCATION (City, town, or county) (State) Baltimore 25, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes 130 E. Fort Ave.		ADDRESS	
24a. REC'D BY REGISTRAR DATE Jan 14 57		24b. REGISTRAR'S SIGNATURE Dee Leach	

354
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 1 month		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13x22 Ellicott City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6114 Rich Avenue				d. STREET ADDRESS 146 Fells Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First AMEY Middle EDNAR Last SCOTT				4. DATE OF DEATH Month January Day 15 Year 1957			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 21, 1891	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic Duties				10b. KIND OF BUSINESS OR INDUSTRY Housework		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James Barnes				14. MOTHER'S MAIDEN NAME Annie Owens			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-30-6351		17. INFORMANT Mrs. Anna Foreman Address 38 A Winters Avenue Catonsville 28, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma - Peritoneum 151X DUE TO adenocarcinoma - Liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO adenocarcinoma - Stomach (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Arterio-sclerotic heart disease							INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 20, 1955 to Jan. 15, 1956 , that I last saw the deceased alive on January 15, 1957 , and that death occurred at M. from the causes and on the date stated above. For the Johns Hopkins Hospital ADDRESS (Street, city or town, state) 601 N. Broadway, Baltimore 5, Md. DATE SIGNED 1/17/57							
ACTUAL SIGNATURE HARRY L. CHANT, M.D.		PHYSICIAN'S NAME (Type) ASSISTANT DIRECTOR, THE JOHNS HOPKINS HOSPITAL					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/18/57		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Easton Sons ADDRESS Catonsville 28, Md.				24a. REC'D BY REGISTRAR JAN 21 57		24b. REGISTRAR'S SIGNATURE W. H. Beach	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JAN 21 1957

BUREAU V. S.

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0035138

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MASS. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. LENGTH OF STAY IN 1b 2 WKS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1705 EDGEWOOD RD. APT. D		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MILFORD 58x3	
3. NAME OF DECEASED (Type or print) First JOHN Middle VINCENT Last SENNOTT		4. DATE OF DEATH Month JAN Day 12 Year 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ?
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ATTENDANT		10b. KIND OF BUSINESS OR INDUSTRY HOSPITAL	
11. BIRTHPLACE (State or foreign country) MASS.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE N. SENNOTT		14. MOTHER'S MAIDEN NAME CAREY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 018-05-0339	
17. INFORMANT GEORGE SENNOTT		Address 1705 EDGEWOOD RD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 8 YRS.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE William A. Pillsbury M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William A. Pillsbury		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 1/13/57	
22c. NAME OF CEMETERY OR CREMATORY St Mary's Cem.		22d. LOCATION (City, town, or county) (State) Milford Mass	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook ADDRESS Baltimore - Md.		24a. REC'D BY REGISTRAR JAN 14 1957	
		24b. REGISTRAR'S SIGNATURE Mabel Gray	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, date, time, place, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. S.

JAN 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00352
32356
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Webster Shipley</u>		4. DATE OF DEATH Month Day Year <u>Jan. 31, 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 6, 1913</u>
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpentier</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Arthur A. Shipley</u>		14. MOTHER'S MAIDEN NAME <u>Nina E. Stocksdales</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>W.W. 2</u>		16. SOCIAL SECURITY NO. <u>212-01-5396</u>	
17. INFORMANT <u>Mrs. Nina E. Shipley</u>		Address <u>206 Oak Ave., Pikesville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Art. Sclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple Sclerosis - 8 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>1 yr.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 19, 1949</u> to <u>Jan 31, 1957</u> , that I last saw the deceased alive on <u>Jan 30, 1957</u> , and that death occurred at <u>10:42 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James A. Miller, MD.</u>		DATE, SIGNED <u>2/1/57</u>	
PHYSICIAN'S NAME (Type) <u>James A. Miller, MD.</u>		ADDRESS (Street, city or town, state) <u>Pikesville - MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 4, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank J. Newell</u>		24a. REC'D BY REGISTRAR <u>DATE 4 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Dorothy Newell</u>			

RECEIVED

FEB 4 1957

BUREAU V. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00353

357

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 33 Hanover Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edward Middle Shugars Last Shugars		4. DATE OF DEATH Month Jan. Day 24 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 1, 1872
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Painter		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Shugars		14. MOTHER'S MAIDEN NAME Julia Yingling	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Mrs. J. Selman Biehl, Westminster, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic C.-V. Disease 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			INTERVAL BETWEEN ONSET AND DEATH 6 mos.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 19 p. m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none
20f. (City or town) none		(County) (State)	
21. I certify that I attended the deceased from Feb. 21, 1943 , to Jan. 24, 1957 , that I last saw the deceased alive on Jan. 23, 1957 , and that death occurred at 8 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Hanover Rd., Reisterstown, Md. DATE SIGNED 1-25-57			
ACTUAL SIGNATURE D. D. Caples		M.D. 6 Hanover Rd., Reisterstown, Md.	
PHYSICIAN'S NAME (Type) D. D. Caples, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 27, 57	22c. NAME OF CEMETERY OR CREMATORY All Saints	22d. LOCATION (City, town, or county) (State) Reisterstown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons Reisterstown, Md.		24a. REC'D BY REGISTRAR 1-24-57	
ADDRESS		24b. REGISTRAR'S SIGNATURE Mary B. Eline	

MARYLAND STATE DEPARTMENT OF HEALTH

00354

358

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

Item 9 Film G209 1-11-57 et

1. PLACE OF DEATH- COUNTY <u>Baltimore,</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>✓</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville,</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House in The Pines 16 Eusting Ave.</u>		STREET ADDRESS (If rural, give location) <u>5413 Penbroke Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>William C. Skinner</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 2, 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>Dec. 24, 1871</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>lawyer</u>	9. AGE last birthday <u>86 85 yrs.</u>
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Truman Skinner</u>		14. MOTHER'S MAIDEN NAME <u>Isabelle Constable</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, nn, or unknown) (If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Mrs. Ruth Bowers 5413 Penbroke Ave.</u>	
16. SOCIAL SECURITY No.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Acute Myocardial Decompensation

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Chronic Hypertensive Cardio-Vascular Disease

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

TIME (Month) (Day) (Year) (Hour) OF INJURY m. INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-20, 1956, to 1-2, 1957, that I last saw the deceasedalive on 1-1, 1957, and that death occurred at 7:30 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)
Burial

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

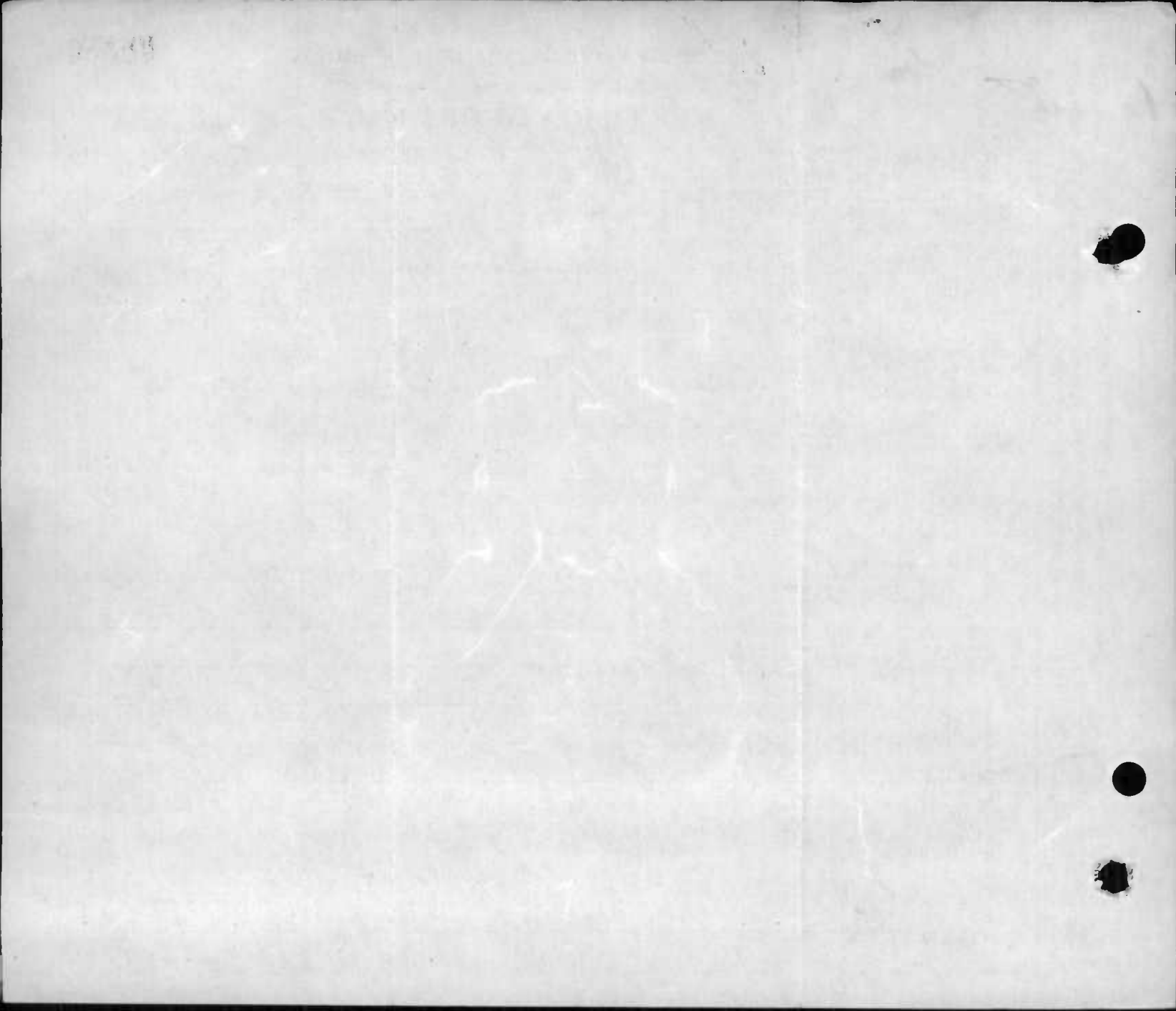
ADDRESS

John O. Mitchell & Sons Inc. 1900 Eutaw Pl.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00355

33

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Byway Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Annie Middle I. Last Smith		4. DATE OF DEATH Month Jan. Day 24 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 1885
9. AGE (In years and birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Wolfenden		14. MOTHER'S MAIDEN NAME Charlotte Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Helen Foster		Address 6065 Falls Rd. Baltimore 9k Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Angina Pectoris 420.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 260x (b) Arteriosclerotic C-V Disease DUE TO 2 yrs. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes			INTERVAL BETWEEN ONSET AND DEATH 9 mos.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. none 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> none	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none
20f. (City or town) none		(County) (State)	
21. I certify that I attended the deceased from Apr. 9 , 19 56 , to Jan. 24 , 19 57 , that I last saw the deceased alive on Jan. 18 , 19 57 , and that death occurred at 2 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Hanover Rd. DATE SIGNED 1-25-57			
ACTUAL SIGNATURE D. D. Caples		M.D. 6 Hanover Rd.	
PHYSICIAN'S NAME (Type) D. D. Caples, M.D.		Reisterstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-26-57	22c. NAME OF CEMETERY OR CREMATORY Druid Ridge	22d. LOCATION (City, town, or county) (State) Pikesville Md.
23. FUNERAL DIRECTOR'S SIGNATURE Frank W. Seitz ADDRESS 814 W. 36th St., Balto., Md.		24a. REC'D BY REGISTRAR DATE Jan. 25 1957	
24b. REGISTRAR'S SIGNATURE Mary Eline			

BUREAU V. 5

JAN 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

360

CERTIFICATE OF DEATH

Reg. Dist. No.

003561

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore - 7				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Baltimore - 7			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5604 Gwynn Oak Ave.				d. STREET ADDRESS 5604 Gwynn Oak Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First IMOGENE Middle C. Last SMITH		4. DATE OF DEATH Month Jan. Day 17 Year 19 57					
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 28, 1901	9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Zellers		14. MOTHER'S MAIDEN NAME Anna J. Dooley					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Pauline Collins - 5604 Gwynn Oak Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410X RHEUMATIC Heart Disease & M.S. + I. acute S. + I., ataxial fibrillation. DUE TO (b) 30 years DUE TO (c) 30 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-24 , 19 49 , to 1-17 , 19 52 , that I last saw the deceased alive on 1-15-57 , 19 57 , and that death occurred at 11:30 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Leon Ashman		M.D. 5907 Gwynn Oak Ave		ADDRESS (Street, city or town, state) Balto. 7, Md.		DATE SIGNED 1-18-57	
PHYSICIAN'S NAME (Type) LEON ASHMAN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/21/57		22c. NAME OF CEMETERY OR CREMATORY Louder Park Cem.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Balto. 17th				24a. REC'D BY REGISTRAR JAN 22 1957		24b. REGISTRAR'S SIGNATURE Dr. J. M. Martin	

MEDICAL CERTIFICATION

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00357

361

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>New Jersey</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 1b <u>134 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Vaux Hall 67x-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>384 Tower Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>RALPH</u> Middle <u>(NMI)</u> Last <u>SMITH</u>				4. DATE OF DEATH Month <u>January</u> Day <u>11</u> Year <u>19 57</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>COLORED</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1897</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SIDNEY R. SMITH</u>				14. MOTHER'S MAIDEN NAME <u>MARY R. RANKINS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT Address <u>Clin. Rec. Vets Admin. Hospital, Fort Howard, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF RIGHT TONSIL</u> <u>145x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>BRONCHO-PNEUMONIA</u>						INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 30</u> , 19 <u>56</u> , to <u>January 11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>January 11</u> , 19 <u>57</u> , and that death occurred at <u>11:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Veterans Administration Hospital</u> <u>1/12/57</u> ACTUAL SIGNATURE <u>D. D. Mark</u> M.D. <u>Veterans Administration Hospital</u> PHYSICIAN'S NAME (Type) <u>D. D. MARK, M. D.</u> <u>Fort Howard, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		22b. DATE THEREOF <u>1/15/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Heavenly Rest Memorial Park Hanover Co., N.J.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Charles R. Lee Mortuary, 802 O'Medison Ave. Balt.</u>				24a. REC'D BY REGISTRAR DATE <u>Jan 15-57</u>		24b. REGISTRAR'S SIGNATURE <u>Darwin L. Fack</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 FilmG210 2-1-57 et

362

CERTIFICATE OF DEATH

00358

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown				c. LENGTH OF STAY IN 1b 10 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Silver Cross Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Jane Last Snyder				4. DATE OF DEATH Month Jan. Day 26, Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 19, 1870		9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Snyder				14. MOTHER'S MAIDEN NAME Mary Jane Ogier			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Miss Rosalind Snyder, 4632 Schenley Rd., Balto. 10, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia 501x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Naso-pharyngitis & Bronchitis DUE TO (c) 10 days						INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Epilepsy & Mixed tumor of parotid gland						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I attended the deceased from 6-7-50 , 19____, to 1-26-57 , 19____, that I last saw the deceased alive on 1-25-57 , 19____, and that death occurred at 6 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Hanover Rd. DATE SIGNED 1-26-57							
ACTUAL SIGNATURE D. D. Caples		M.D. 6 Hanover Rd.		DATE SIGNED 1-26-57			
PHYSICIAN'S NAME (Type) D. D. Caples, M. D.		Reisterstown, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 28, 1957		22c. NAME OF CEMETERY OR CREMATORY Green Mount		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons Inc. 1900 Eutaw Place				ADDRESS 1900 Eutaw Place		24a. REC'D BY REGISTRAR Mary Elise	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JAN 28 1957

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

DECEASED'S NAME [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF BIRTH [Faint text]		PLACE OF BIRTH [Faint text]		OCCUPATION [Faint text]	
DATE OF DEATH [Faint text]		PLACE OF DEATH [Faint text]		CAUSE OF DEATH [Faint text]	
TIME OF DEATH [Faint text]		MANNER OF DEATH [Faint text]		MEDICAL HISTORY [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
SIGNATURE OF CLERK [Faint text]		SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF JUDGE [Faint text]	

BUREAU V. 8

JAN 28 1957

RECEIVED

John O. Nelson II & Sons Inc. 1800 Tupper Place

JAN 28 1957

363

CERTIFICATE OF DEATH

Reg. Dist. No.

00359

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>3101.4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE BALTO CO. MD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CATON RIDGE NURSING</u>		d. STREET ADDRESS <u>1226 N BRADFORD</u> IS RESIDENCE ON A FARM? <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELIZABETH G. SOWERS</u>		4. DATE OF DEATH <u>1/30/57</u> 19 <u>57</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/6/1877</u>
9. AGE (In years lost birthday) <u>79</u> yrs.		IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WM. HOFFMAN</u>		14. MOTHER'S MAIDEN NAME <u>CATH. DETTERMAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>17. INFORMANT</u> Address <u>EDWARD SOWERS</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>Approx 10yr</u> <u>Unknown</u> <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12/30</u> , 19 <u>56</u> , to <u>1/30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/19</u> , 19 <u>57</u> , and that death occurred at <u>5:42</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Cliff Ratliff</u> M.D.		ADDRESS (Street, city or town, state) <u>4605 Edmondson Ave</u> DATE SIGNED <u>1/31/57</u>	
PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFF, JR.</u>		<u>4605 EDMONDSON AVE</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/2/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HOLY CROSS</u>	22d. LOCATION (City, town, or county) (State) <u>RITCHIE HEIGHTS</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN J. FAHEY</u> ADDRESS <u>1318 LIGHT</u>		24a. REC'D BY REGISTRAR <u>1/31/57</u>	24b. REGISTRAR'S SIGNATURE <u>Paul</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00360

CERTIFICATE OF DEATH

Reg. Dist. No.

44

361

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Point</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Point</u> x2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1129 H. St.</u>				d. STREET ADDRESS <u>1129 H. Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Fannie</u> Middle <u>Elizabeth</u> Last <u>Spicer</u>				4. DATE OF DEATH Month <u>January</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 4, 1873</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>83</u> Days <u>83</u> Hours <u>83</u> Min. <u>83</u>		IF UNDER 24 HRS. Months <u>83</u> Days <u>83</u> Hours <u>83</u> Min. <u>83</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Housework</u>							
13. FATHER'S NAME <u>Thomas G. Higgs</u>				14. MOTHER'S MAIDEN NAME <u>Carolina Croft</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>No.</u>			
17. INFORMANT <u>Ollie Dietrich</u> Address <u>1129 H. St.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Streptococcal Pneumonia</u> DUE TO <u>171X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of Cervix</u> DUE TO <u>5 yrs</u> (c) <u>5 yrs</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan 11</u> , 19 <u>56</u> , to <u>Jan 11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 11</u> , 19 <u>57</u> , and that death occurred at <u>5:20 P.M.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James T. Means</u>				ADDRESS (Street, city or town, state) <u>520 D St. Balto. Md</u> DATE SIGNED <u>1/11/57</u>			
PHYSICIAN'S NAME (Type) <u>James T. Means</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/14/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Shenandoah E. U. Church</u>		22d. LOCATION (City, town, or county) (State) <u>Shenandoah Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Ambrose, Jr.</u> ADDRESS <u>1328 Sulphur Sp. Rd.</u>				24a. REC'D BY REGISTRAR <u>15 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dawson L. Barber</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH		6. PLACE OF DEATH	
7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. PLACE OF BIRTH		11. DATE OF BIRTH		12. SEX OF BIRTH	
13. NAME OF PHYSICIAN		14. NAME OF HOSPITAL		15. NAME OF NURSE		16. NAME OF MINISTER		17. NAME OF CHURCH		18. NAME OF FUNERAL HOME	
19. NAME OF CORONER		20. NAME OF JURY		21. NAME OF JUDGE		22. NAME OF CLERK		23. NAME OF SHERIFF		24. NAME OF DEPUTY SHERIFF	
25. NAME OF WITNESS		26. NAME OF WITNESS		27. NAME OF WITNESS		28. NAME OF WITNESS		29. NAME OF WITNESS		30. NAME OF WITNESS	
31. NAME OF WITNESS		32. NAME OF WITNESS		33. NAME OF WITNESS		34. NAME OF WITNESS		35. NAME OF WITNESS		36. NAME OF WITNESS	
37. NAME OF WITNESS		38. NAME OF WITNESS		39. NAME OF WITNESS		40. NAME OF WITNESS		41. NAME OF WITNESS		42. NAME OF WITNESS	
43. NAME OF WITNESS		44. NAME OF WITNESS		45. NAME OF WITNESS		46. NAME OF WITNESS		47. NAME OF WITNESS		48. NAME OF WITNESS	
49. NAME OF WITNESS		50. NAME OF WITNESS		51. NAME OF WITNESS		52. NAME OF WITNESS		53. NAME OF WITNESS		54. NAME OF WITNESS	
55. NAME OF WITNESS		56. NAME OF WITNESS		57. NAME OF WITNESS		58. NAME OF WITNESS		59. NAME OF WITNESS		60. NAME OF WITNESS	
61. NAME OF WITNESS		62. NAME OF WITNESS		63. NAME OF WITNESS		64. NAME OF WITNESS		65. NAME OF WITNESS		66. NAME OF WITNESS	
67. NAME OF WITNESS		68. NAME OF WITNESS		69. NAME OF WITNESS		70. NAME OF WITNESS		71. NAME OF WITNESS		72. NAME OF WITNESS	
73. NAME OF WITNESS		74. NAME OF WITNESS		75. NAME OF WITNESS		76. NAME OF WITNESS		77. NAME OF WITNESS		78. NAME OF WITNESS	
79. NAME OF WITNESS		80. NAME OF WITNESS		81. NAME OF WITNESS		82. NAME OF WITNESS		83. NAME OF WITNESS		84. NAME OF WITNESS	
85. NAME OF WITNESS		86. NAME OF WITNESS		87. NAME OF WITNESS		88. NAME OF WITNESS		89. NAME OF WITNESS		90. NAME OF WITNESS	
91. NAME OF WITNESS		92. NAME OF WITNESS		93. NAME OF WITNESS		94. NAME OF WITNESS		95. NAME OF WITNESS		96. NAME OF WITNESS	
97. NAME OF WITNESS		98. NAME OF WITNESS		99. NAME OF WITNESS		100. NAME OF WITNESS		101. NAME OF WITNESS		102. NAME OF WITNESS	

BUREAU V. S.

JAN 15 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00361

212

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Ma. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5552 Ashbourne Rd.		d. STREET ADDRESS 5552 Ashbourne Rd.	
3. NAME OF DECEASED (Type or print) Carl Harrison Spurrier		4. DATE OF DEATH Jan. 8/57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 2, 1890
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY B. & O. R.R.	
11. BIRTHPLACE (State or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John H. Spurrier		14. MOTHER'S MAIDEN NAME Laura Beall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Clara M. Spurrier		Address 5552 Ashbourne Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Advanced Generalized Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Liver cirrhosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 1955 , to Jan 8, 1957 , that I last saw the deceased alive on Jan 8, 1957 , and that death occurred at 9:15 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Justinus Kudirka		ADDRESS (Street, city or town, state) 2151 Wilkens Ave Balt., Md.	
DATE SIGNED 1.10.57			
PHYSICIAN'S NAME (Type) J. Kudirka		Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 12/57	22c. NAME OF CEMETERY OR CREMATORY Loudon Park	22d. LOCATION (City, town, or county) (State) Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE Harvey H. Witzke		ADDRESS 4101 Edmondson Ave.	
24a. REC'D BY REGISTRAR Dr. Geo. M. Zuppers		DATE 1-11-1957	

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

201

CERTIFICATE OF DEATH

Reg. Dist. No. 00362 41

1. PLACE OF DEATH a. COUNTY <i>Baltimore 22</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>as</i> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Dundalk</i>				c. LENGTH OF STAY IN 1b <i>25 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>53 m</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7526 New Battle Shore Circle</i>				d. STREET ADDRESS <i>1 #1</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>MARIE CLARA SRAMEK</i>				4. DATE OF DEATH <i>JAN 1 1957</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Aug 11 1878</i>	
9. AGE (In years last birthday) <i>78</i> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>		11. BIRTHPLACE (State or foreign country) <i>Bohemia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>James Kazda</i>				14. MOTHER'S MAIDEN NAME <i>Anna (last unknown)</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Charles Schramet (in #1)</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443X Acute myocardial failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive Cardiovascular disease</i> DUE TO (c) <i>Atherosclerosis</i>				INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> <i>10 yrs</i> <i>10 yrs</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Fracture both bones of right wrist Dec 10/56</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>not contributory to death</i>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1/16</i> , 19 <i>54</i> to <i>Nov 1</i> , 19 <i>57</i> that I last saw the deceased alive on <i>Dec 29</i> , 19 <i>56</i> , and that death occurred at <i>7:30</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Louis N. Tollin</i> M.D.				ADDRESS (Street, city or town, state) <i>6908 N. Point Rd Balto - 19 - Md</i>			
PHYSICIAN'S NAME (Type) <i>LOUIS N. TOLLIN</i>				DATE SIGNED <i>1/1/57</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/4/57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Oak Hill Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Schimunek Funeral Home, 2601 E. Madison St.</i>				ADDRESS		24a. REC'D BY REGISTRAR <i>1957</i>	
				24b. REGISTRAR'S SIGNATURE <i>Wm. M. Kelley</i>			

JAN 4 1957

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365

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>111 Birchwood Rd.</u>				d. STREET ADDRESS <u>111 Birchwood Rd.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Frederick Conrad Staas</u>				4. DATE OF DEATH Month Day Year <u>Jan 3 19 57</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 5, 1875</u>		9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Metallurgist Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Brass & Metal</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Wilhelm Staas</u>				14. MOTHER'S MAIDEN NAME <u>Mary ---</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. John Tussing 111 Birchwood Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Decompenstation</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Ch. Hypertensive Cardio-Vascular Disease</u> DUE TO (b) <u>?</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture Left Hip 11/28/56 - not a contributing factor</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u> <u>?</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Tripped on rug at home</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While Not while of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-28</u> , 19 <u>56</u> , to <u>1-3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-3</u> , 19 <u>57</u> , and that death occurred at <u>1:50 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wilmer K. Gallager</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>6209 Frederick Rd Catonsville 28 1-4-57</u>			
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallager M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-7-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Ellicott City Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fairly Funeral Home - Catonsville, Md.</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>JAN 8 57</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1922		MOBILE, ALABAMA	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		DATE OF DEATH		PLACE OF DEATH	
1000 E. 10th St., St. Louis, Mo.		Attorney		High School		Married		4/4/68		St. Louis, Mo.	
CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH	
Heart Disease		Natural		1		4/4/68		St. Louis, Mo.		4/4/68	
SIGNATURE OF PHYSICIAN		SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED	
J. Edgar Hoover		James Earl Ray		John F. Kennedy		John F. Kennedy		John F. Kennedy		John F. Kennedy	
DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
4/4/68		St. Louis, Mo.		4/4/68		St. Louis, Mo.		4/4/68		St. Louis, Mo.	

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JAN 8 1967

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366

CERTIFICATE OF DEATH

00364

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTO. CO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) o. STATE <u>md</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. LENGTH OF STAY IN 1b <u>40 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>OWEN R. STAGMER</u>				4. DATE OF DEATH <u>11/29/57</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/5/1903</u>		9. AGE (In years last birthday) <u>53</u>	10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Drug store</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pharmacy</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Eugene Stagner</u>				14. MOTHER'S MAIDEN NAME <u>Claisy Scoggin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Emma Stagner</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X Cerebral Hemorrhage</u> DUE TO (b) <u>Generalized Arterio-Sclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>4-5 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Jan-22, 1957</u> , to <u>Jan-29, 1957</u> , that I last saw the deceased alive on <u>Jan-29, 1957</u> , and that death occurred at <u>7:00</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>S. Lloyd Johnson</u> M.D.				ADDRESS (Street, city or town, state) <u>Catonville, md</u>			
PHYSICIAN'S NAME (Type) <u>S. Lloyd Johnson, M.D.</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/1/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Towson md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mac Suttow</u> ADDRESS <u>28</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				DATE <u>12/4/57</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bethlehem Steel Hospital				d. STREET ADDRESS 2402 Manning Ave. 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Edw Middle E Last Stark				4. DATE OF DEATH Month 1-11-57 Day Year 19			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 12, 1894		9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Koppers Company		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Stark				14. MOTHER'S MAIDEN NAME Ann Bittinger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Alma G. Stark, 2402 Manning Avenue			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M.B. Davis				M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) M.B. Davis, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 1/11/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 1-14-57		22c. NAME OF CEMETERY OR CREMATORY Bittinger Cemetery		22d. LOCATION (City, town, or county) (State) Bittinger, Md. (Garrett Co)	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR JAN 14 1957			
				24b. REGISTRAR'S SIGNATURE Laws and Larkins			

TO DENY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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RECEIVED

TO BE OBTAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00366

368

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH o. COUNTY Baltimore M. STATE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Washington, D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 1 Yr. 1 Mo. 14 Das.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sheppard & Enoch Pratt Hosp. Towson 4, Maryland		d. STREET ADDRESS 4301 Massachusetts Ave., N. W.	
3. NAME OF DECEASED (Type or print) First Ruth Middle Service Last Stidham		4. DATE OF DEATH Month January Day 23 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 26, 1906
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY Tire Business	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Robert J. Service		14. MOTHER'S MAIDEN NAME Laura Lindeman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Hospital Records	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Endocarditis 414X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Rheumatic Fever DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 8 yr 10 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anxiety Reaction		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 9, 1955 to Jan 23, 1957 , that I last saw the deceased alive on Jan 22, 1957 , and that death occurred at 8:45 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. W. Elgin		DATE SIGNED 1/23/57	
PHYSICIAN'S NAME (Type) William W. Elgin, M. D.		ADDRESS (Street, city or town, state) Towson 4, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Jan 25, 1957		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Leedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. William Lewis Sonico		24. REG'D BY REGISTRAR Jan 25 1957	
ADDRESS 300 - 4th St. N. W.		24b. REGISTRAR'S SIGNATURE Mabel Gray	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist. No.

369

CERTIFICATE OF DEATH

00367

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND N. Y. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York City. 64X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION College Manor Nursing Home				d. STREET ADDRESS 200 E. 66th. Street			
3. NAME OF DECEASED (Type or print) First Wilson Middle Breckenridge Last Stringer				4. DATE OF DEATH Month Jan Day 1 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 11, 1880	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Contracting Engineer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cockeysville, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas C. Stringer				14. MOTHER'S MAIDEN NAME Mary Haughy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Howard C. Marchant 222 Oakdale Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary fibrosis + infection 526X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchiectasis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease						INTERVAL BETWEEN ONSET AND DEATH 2-3 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May , 19 56 , to Jan. 1 , 19 57 , that I last saw the deceased alive on Dec. 28 , 19 56 , and that death occurred at 9:20 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 E. Eager St., Baltimore 2, Md. DATE SIGNED Jan 2, 1957							
ACTUAL SIGNATURE Crawford N. Kirkpatrick Jr.		PHYSICIAN'S NAME (Type) CRAWFORD N. KIRKPATRICK, JR., MD					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/3/57		22c. NAME OF CEMETERY OR CREMATORY Reisterstown Methodist Church Cemetery, Reisterstown, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE H. W. Means & Son 805 N. Calvert Street		ADDRESS		24a. REC'D BY REGISTRAR DATE JAN 4 '57		24b. REGISTRAR'S SIGNATURE W. Beach	

00368

370

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Parkville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2805 Alden Rd.</u>		d. STREET ADDRESS <u>12805 Alden Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Grete Margaret Strobel</u>		First Middle Last		4. DATE OF DEATH <u>Jan.</u> Month <u>12</u> Day <u>1957</u> Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 10, 1904</u>		9. AGE (In years last birthday) <u>52</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
13. FATHER'S NAME <u>Hans Schmitt</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>213-36-4607</u>		17. INFORMANT <u>Mr. William K. Strobel</u> Address <u>2805 Alden Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive CVD.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. _____ Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>1/12</u> , 19 <u>57</u> , to <u>1/12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/12/57</u> , 19 <u>57</u> , and that death occurred at <u>2:30</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>H. A. G. Bott, M.D.</u> M.D. <u>8100 Harford Rd.</u> PHYSICIAN'S NAME (Type) <u>H. A. G. BOTT, M.D.</u> <u>Belt 14, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/15/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>	
22d. LOCATION (City, town, or county) <u>Baltimore</u>		(State) <u>Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck Inc.</u> ADDRESS <u>5305 Harford Rd.</u>	
24a. REC'D BY REGISTRAR DATE <u>JAN 15 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. R. M. Bacon</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

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VS A1S (4)
ISM 9/SS

U.S. MARINE CORPS

BUREAU V. S.

JAN 15 1957

RECEIVED

371 CERTIFICATE OF DEATH

0036931

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) <u>RURAL - LIBERTY GARDENS</u>				c. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) <u>RURAL - LIBERTY GARDENS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3439 LIBERTY GARDEN RD.</u>				d. STREET ADDRESS <u>1 3439 LIBERTY GARDEN RD.</u>			
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Alphonse</u> Last <u>Stromberg</u>				4. DATE OF DEATH Month <u>1</u> Day <u>18</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 7, 1886</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN HENRY STROMBERG</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE STEVER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-05-8500</u>		17. INFORMANT Address <u>WIFE - ADA B. STROMBERG</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>5 YEARS</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>8/25</u> , 19 <u>55</u> , to <u>1/18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/7</u> , 19 <u>57</u> , and that death occurred at <u>530 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edwin G. Purpurt</u>				ADDRESS (Street, city or town, state) <u>8204 LIBERTY RD, BALTO. MD.</u>			
SIGNATURE'S NAME (Type) <u>Edwin G. Purpurt, M.D.</u>				DATE SIGNED <u>1/18/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-21-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard Strong</u>				ADDRESS <u>307 W. North Ave</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 21 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Dr. Wm. Martin</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. S.

JAN 21 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 2 FilmG210 1-29-57 et

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balti</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK-32</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 Baltimore 22</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>7834 St. Gregory's Drive</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Robert</u> First Middle Last <u>Sudbrink</u>		4. DATE OF DEATH <u>JAN</u> Month <u>19</u> Day <u>1957</u> Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 12/1932</u>
9. AGE (In years last birthday) <u>25</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Helper Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Beth Steel Corp</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>J. William Sudbrink</u>		14. MOTHER'S MAIDEN NAME <u>Frances Marvel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>219-28-0011</u>	
17. INFORMANT <u>Mrs. Sudbrink</u>		Address <u>125 Bayside Drive</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DROWNING-</u> <u>929.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>FELL Thru ice in Bear Creek NR Inverness-</u>	
20c. TIME OF INJURY <u>1:45</u> p. m. <u>1/19/57</u> 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Bear Creek</u>	20f. (City or town) (County) (State) <u>NR Dundalk-22</u> <u>Balti</u> <u>MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>M.B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M.B. DAVIS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 22/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Belair Mem. Garden</u>		22d. LOCATION (City, town, or county) (State) <u>Belair MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Philip's Herwig Sons</u>		ADDRESS <u>2024 Orleans St</u>	
24a. REC'D BY REGISTRAR <u>Jan 23 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Thm. Kelly</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

In rescue of two children.

1/27/57-QS.

BUREAU V. S.

JAN 28 1957

RECEIVED

372

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. LENGTH OF STAY IN 1b <u>52 CATONSVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>64 N. PROSPECT AVE</u>				d. STREET ADDRESS <u>1 64 N. PROSPECT AVE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>IDA</u> Middle <u>E.</u> Last <u>SUSSMAN</u>				4. DATE OF DEATH Month <u>JAN.</u> Day <u>18</u> Year <u>19 57</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 10, 1891</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months <u>65</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>MD.</u>	
13. FATHER'S NAME <u>CLARK</u>				14. MOTHER'S MAIDEN NAME <u>NOT KNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Abel Susman - 64 N. Prospect Ave., 78</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>443 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Hypertensive CVD</u> (c) <u>Senility, malnutrition</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>14 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>April 28</u> , 19 <u>55</u> , to <u>Jan 18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 29</u> , 19 <u>56</u> , and that death occurred at <u>11:00</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stephen Lee Magness</u>				ADDRESS (Street, city or town, state) <u>908 Frederick Rd. Catonsville, Md</u>			
PHYSICIAN'S NAME (Type) <u>STEPHEN LEE MAGNESS</u>				DATE SIGNED <u>1-19-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-21-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Blow Haven Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Blow Haven, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Turner Home, Catonsville, Md.</u>				ADDRESS <u>Wm. J. Turner Home, Catonsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 23 '57</u>	24b. REGISTRAR'S SIGNATURE <u>Wm. J. Turner</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00372

Reg. Dist. No. 37

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>2mth3dys</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edna</u> Middle <u>M.</u> Last <u>Talbert</u>		4. DATE OF DEATH Month <u>January</u> Day <u>25</u> , Year <u>19 57</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 26, 1895</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Theodore Shaffer</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Shaffer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 23</u> , 19 <u>57</u> , to <u>Jan. 25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan. 25</u> , 19 <u>57</u> , and that death occurred at <u>10:05 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u> DATE SIGNED <u>1-25-57</u>			
ACTUAL SIGNATURE <u>Stella Wachslar</u>		M.D. <u>SPRING GROVE STATE HOSPITAL</u>	
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>		<u>Catonsville 28, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-28-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hampstead</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward C. Tipton</u>		ADDRESS <u>Hampstead Md</u>	
24a. REC'D BY REGISTRAR <u>1/26/57</u>		24b. REGISTRAR'S SIGNATURE <u>Harry Peters</u>	
DATE <u>JAN 29 57</u>			

9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 1041 1042 1043 10

1000

BUREAU V. S.

JAN 29 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages should be removed from the certificate and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film 6211 3-4-57 et

CERTIFICATE OF DEATH

00373

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3vol-4	
c. LENGTH OF STAY IN 1b 5yr5mth8dys		d. STREET ADDRESS North Avenue 5313 Edmondson Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lorentze Middle Taraldsen Last Taraldsen		4. DATE OF DEATH Month January 2, Day 19 Year 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1867
9. AGE (In years lost birthday) 89 yrs.		IF UNDER 1 YEAR Months 89 Days 89 Hours 89 Min.	IF UNDER 24 HRS. Months 89 Days 89 Hours 89 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Oslo, Norway		12. CITIZEN OF WHAT COUNTRY? Norway	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Mr. Earle Taraldsen - Calchester Hall, Scarsdale,		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, generalized and severe DUE TO (c) --			INTERVAL BETWEEN ONSET AND DEATH N.Y.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1953 to Jan. 2, 1957 that I last saw the deceased alive on Jan. 2, 1957 , and that death occurred at 11:00pM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 1-2-57	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-5-57	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Queens, New York	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook		24a. REC'D BY REGISTRAR 1/3/57	
ADDRESS 1217 St. Paul Street		24b. REGISTRAR'S SIGNATURE W. S. Smith	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		MALE		38		JAN 15 1919	
PLACE OF BIRTH		RACE		OCCUPATION		EDUCATION	
BALTIMORE, MARYLAND		WHITE		LABORER		HIGH SCHOOL	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
JAN 20 1957		BALTIMORE, MARYLAND		HEART DISEASE		NATURAL	
TIME OF DEATH		TEMPERATURE		PULSE		RESPIRATION	
10:00 AM		98.6		60		20	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 20 1957		JAN 20 1957		JAN 20 1957		JAN 20 1957	

RECEIVED
JAN 2 1957
BUREAU V. 8

CERTIFICATE OF DEATH

00374

Reg. Dist. No.

MEDICAL CERTIFICATION

452111

BUREAU V. S.

JAN 16 1957

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00375

376 CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Balto</i>	MARYLAND	STATE <i>Md</i>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <i>Timonium</i>		TOWN <i>Baltimore</i>	
HOSPITAL OR STREET ADDRESS <i>Stillman Hospice</i>		STREET ADDRESS (If rural give location) <i>3401-4</i>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <i>ROSE</i> (Middle) <i>TRAGESER</i> (Last)		(Month) <i>1</i> (Day) <i>11</i> (Year) <i>57</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>June 26 1865</i>
9. AGE last birthday <i>91</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Wilhelm Sommers</i>		14. MOTHER'S MAIDEN NAME <i>S</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS <i>John Trageser 1719 Corsuch Ave</i>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
442X IMMEDIATE CAUSE (A) <i>Pulmonary Edema</i>		INTERVAL BETWEEN ONSET AND DEATH <i>48 Hrs</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Hypertensive Cardio-Renal</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Vascular Disease</i>		10 yrs.	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Oct 19 53</i> to <i>Jan 11 57</i> , that I last saw the deceased alive on <i>Jan 11 57</i> , and that death occurred at <i>5:00 P.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>Charles F. O'Donnell</i> M.D.		ADDRESS (Street, city, town, state) <i>1111/57</i>	
DATE SIGNED <i>1/11/57</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Jan 14 1957</i>	
NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer</i>		LOCATION (City, town, or county) <i>Baltimore Md</i>	
24. REC'D BY REGISTRAR <i>A. W. Hedrick</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>J. Melville Jenkins</i>	
DATE <i>1/15/57</i>		ADDRESS <i>2713 Kirk Ave</i>	

CERTIFICATE OF DEATH

STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD.

Form No. 100

1. NAME OF DECEASED

MARYLAND

DATE OF DEATH

PLACE OF DEATH

2. SEX AND AGE

3. OCCUPATION

4. CAUSE OF DEATH

5. PLACE OF BIRTH

6. DATE OF BIRTH

7. SEX

8. AGE

9. OCCUPATION

10. PLACE OF DEATH

RECEIVED

BUREAU V. S.

JAN 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00376

Reg. Dist. No.

39

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monkton, (rural)</u>		c. LENGTH OF STAY IN lb <u>14 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monkton, (rural)</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Corbett</u>				d. STREET ADDRESS <u>Corbett</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Margaret Henrietta Treadway</u> First Middle Last				4. DATE OF DEATH <u>Jan 15</u> 19 <u>57</u> Month Day Year			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-12-1869</u>		9. AGE (In years last birthday) <u>87</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Maurice Dapprich</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Nau</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Amelia A. Treadway, Monkton, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Vascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>56 17 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>A. M. France</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>A. M. F. FRANCE</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-18-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns (Waverley)</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. City, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. Scott Brooks</u>				24a. REC'D BY REGISTRAR <u>Jan 21 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Elij. Gouches</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU Y. S.

JAN 21 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00377

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md b. COUNTY Balto	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto 34		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9418 Old Harford Road		d. STREET ADDRESS 9418 Old Harford Rd Balto	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Clarence Leroy Trout		4. DATE OF DEATH Month Day Year Jan 8 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 9, 1907
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician Bethlehem Steel Co		10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Glen Le Roy Trout		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-01-0355	
17. INFORMANT Mrs. Grace E. Trout, 9418 Old Harford		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Chronic Coronary Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Atherosclerosis moderately severe PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 hrs 8 yrs \neq undet	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John C. Hyle		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John C Hyle		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 1-9-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/11/1957	
22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Harford Road #14		24a. REC'D BY REGISTRAR DATE JAN 10 1957	
		24b. REGISTRAR'S SIGNATURE Dr. A. M. Becong	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF DEATH</p>	
<p>5. PLACE OF DEATH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. SIGNATURE OF MEDICAL EXAMINER</p>		<p>10. SIGNATURE OF WITNESS</p>		<p>11. SIGNATURE OF CORONER</p>		<p>12. SIGNATURE OF JURY</p>	
<p>13. SIGNATURE OF DECEASED</p>		<p>14. SIGNATURE OF NEXT OF KIN</p>		<p>15. SIGNATURE OF SURGEON</p>		<p>16. SIGNATURE OF JUDGE</p>	
<p>17. SIGNATURE OF CLERK</p>		<p>18. SIGNATURE OF RECORDER</p>		<p>19. SIGNATURE OF ARCHIVIST</p>		<p>20. SIGNATURE OF DEPUTY</p>	
<p>21. SIGNATURE OF ASSISTANT</p>		<p>22. SIGNATURE OF CLERK</p>		<p>23. SIGNATURE OF RECORDER</p>		<p>24. SIGNATURE OF ARCHIVIST</p>	
<p>25. SIGNATURE OF DEPUTY</p>		<p>26. SIGNATURE OF ASSISTANT</p>		<p>27. SIGNATURE OF CLERK</p>		<p>28. SIGNATURE OF RECORDER</p>	
<p>29. SIGNATURE OF ARCHIVIST</p>		<p>30. SIGNATURE OF DEPUTY</p>		<p>31. SIGNATURE OF ASSISTANT</p>		<p>32. SIGNATURE OF CLERK</p>	
<p>33. SIGNATURE OF RECORDER</p>		<p>34. SIGNATURE OF ARCHIVIST</p>		<p>35. SIGNATURE OF DEPUTY</p>		<p>36. SIGNATURE OF ASSISTANT</p>	
<p>37. SIGNATURE OF CLERK</p>		<p>38. SIGNATURE OF RECORDER</p>		<p>39. SIGNATURE OF ARCHIVIST</p>		<p>40. SIGNATURE OF DEPUTY</p>	
<p>41. SIGNATURE OF ASSISTANT</p>		<p>42. SIGNATURE OF CLERK</p>		<p>43. SIGNATURE OF RECORDER</p>		<p>44. SIGNATURE OF ARCHIVIST</p>	
<p>45. SIGNATURE OF DEPUTY</p>		<p>46. SIGNATURE OF ASSISTANT</p>		<p>47. SIGNATURE OF CLERK</p>		<p>48. SIGNATURE OF RECORDER</p>	
<p>49. SIGNATURE OF ARCHIVIST</p>		<p>50. SIGNATURE OF DEPUTY</p>		<p>51. SIGNATURE OF ASSISTANT</p>		<p>52. SIGNATURE OF CLERK</p>	
<p>53. SIGNATURE OF RECORDER</p>		<p>54. SIGNATURE OF ARCHIVIST</p>		<p>55. SIGNATURE OF DEPUTY</p>		<p>56. SIGNATURE OF ASSISTANT</p>	
<p>57. SIGNATURE OF CLERK</p>		<p>58. SIGNATURE OF RECORDER</p>		<p>59. SIGNATURE OF ARCHIVIST</p>		<p>60. SIGNATURE OF DEPUTY</p>	
<p>61. SIGNATURE OF ASSISTANT</p>		<p>62. SIGNATURE OF CLERK</p>		<p>63. SIGNATURE OF RECORDER</p>		<p>64. SIGNATURE OF ARCHIVIST</p>	
<p>65. SIGNATURE OF DEPUTY</p>		<p>66. SIGNATURE OF ASSISTANT</p>		<p>67. SIGNATURE OF CLERK</p>		<p>68. SIGNATURE OF RECORDER</p>	
<p>69. SIGNATURE OF ARCHIVIST</p>		<p>70. SIGNATURE OF DEPUTY</p>		<p>71. SIGNATURE OF ASSISTANT</p>		<p>72. SIGNATURE OF CLERK</p>	
<p>73. SIGNATURE OF RECORDER</p>		<p>74. SIGNATURE OF ARCHIVIST</p>		<p>75. SIGNATURE OF DEPUTY</p>		<p>76. SIGNATURE OF ASSISTANT</p>	
<p>77. SIGNATURE OF CLERK</p>		<p>78. SIGNATURE OF RECORDER</p>		<p>79. SIGNATURE OF ARCHIVIST</p>		<p>80. SIGNATURE OF DEPUTY</p>	
<p>81. SIGNATURE OF ASSISTANT</p>		<p>82. SIGNATURE OF CLERK</p>		<p>83. SIGNATURE OF RECORDER</p>		<p>84. SIGNATURE OF ARCHIVIST</p>	
<p>85. SIGNATURE OF DEPUTY</p>		<p>86. SIGNATURE OF ASSISTANT</p>		<p>87. SIGNATURE OF CLERK</p>		<p>88. SIGNATURE OF RECORDER</p>	
<p>89. SIGNATURE OF ARCHIVIST</p>		<p>90. SIGNATURE OF DEPUTY</p>		<p>91. SIGNATURE OF ASSISTANT</p>		<p>92. SIGNATURE OF CLERK</p>	
<p>93. SIGNATURE OF RECORDER</p>		<p>94. SIGNATURE OF ARCHIVIST</p>		<p>95. SIGNATURE OF DEPUTY</p>		<p>96. SIGNATURE OF ASSISTANT</p>	
<p>97. SIGNATURE OF CLERK</p>		<p>98. SIGNATURE OF RECORDER</p>		<p>99. SIGNATURE OF ARCHIVIST</p>		<p>100. SIGNATURE OF DEPUTY</p>	

RECEIVED
JAN 10 1957
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00378

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3401-4			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3 Old North Point Road				d. STREET ADDRESS 1501 N. Patterson Park		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELLA Middle E. ULLRICH Last ULLRICH				4. DATE OF DEATH Month January Day 30 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 29, 1894	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 62 Days 62 Hours 62 Min.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Anton Neuman				14. MOTHER'S MAIDEN NAME Josephine Doyas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Jerome W. Ullrich, son,				Address 4205 Sheldon Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Subarachnoid Hemorrhage DUE TO Ruptured Congenital Aneurysm of Left Middle Cerebral Artery Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 330X DUE TO (c) 330X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE William V. Lovitt, Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 1/30/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 2, 1957		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek 3331 Brehms Lane				24a. REC'D BY REGISTRAR FEB 1 1957 24b. REGISTRAR'S SIGNATURE Dawson L. Farley			

BUREAU V. S.

FEB 1 1957

RECEIVED

203

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>				c. LENGTH OF STAY IN 1b <u>28 YRS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3004 DUNLEER RD</u>				d. STREET ADDRESS <u>13004 DUNLEER RD.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>HOMER MERLE VARNER, SR.</u>				4. DATE OF DEATH Month Day Year <u>JAN. 1. 1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAR 16, 1900</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>EXECUTATIVE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>ISAAC H VARNER</u>				14. MOTHER'S MAIDEN NAME <u>ADA NOON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>705-10-9655</u>			
17. INFORMANT Address <u>MINNIE S. VARNER - SAME</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular-Renal Disease</u> DUE TO (c) <u>15 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>4:14 P.M.</u> , 19 <u>56</u> , to <u>Jan. 1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>December 31</u> , 19 <u>56</u> , and that death occurred at <u>4:14 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David Owens</u> M.D. <u>914 D St. Sparrows Point, Md.</u>				DATE SIGNED <u>1/1/57</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Jan 4, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bradley Funeral Home</u> ADDRESS <u>700 Willow Spring Rd, Dundalk</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 3</u>		24b. REGISTRAR'S SIGNATURE <u>Wm M. Kelly</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JAN 3 1957

BUREAU V. 3

380

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson #4		c. LENGTH OF STAY IN 1b 7 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 14 Aigburth Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CLARENCE Middle JAMES Last VELIE		4. DATE OF DEATH Month January Day 29 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 2, 1893.
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months 63 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Music Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Public Schools	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James B. Velie		14. MOTHER'S MAIDEN NAME Adeline White	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Zenith H. Velie		Address 14 Aigburth Road Towson 4, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Generalized Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) 7 yrs. DUE TO (c) 7 yrs.			INTERVAL BETWEEN ONSET AND DEATH 6 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 1956 to January 1957 , that I last saw the deceased alive on January 29, 1957 , and that death occurred at Md. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7501 York Rd Towson #4 Md DATE SIGNED 1/31/57			
ACTUAL SIGNATURE Charles F. O'Donnell M.D.			
PHYSICIAN'S NAME (Type) Charles F. O'Donnell M.D. Towson #4 Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 1, 1957.	22c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery	22d. LOCATION (City, town, or county) (State) Ellicott City, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Easton Sons, Catonsville 28, Md.		24a. REC'D BY REGISTRAR Feb 4 1957	
24b. REGISTRAR'S SIGNATURE Matel Gray			

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

DECEASED NAME LAST FIRST MIDDLE JAMES E. KELLO		SEX MALE		DATE OF BIRTH JAN 10 1890		PLACE OF BIRTH BOSTON MASS	
RACE WHITE		MARRIAGE SINGLE		OCCUPATION LABORER		PLACE OF DEATH BOSTON MASS	
STREET AND NO. 123 WASHINGTON ST		CITY AND STATE BOSTON MASS		COUNTY SUFFOLK		DISTRICT SOUTH	
DATE OF DEATH FEB 4 1957		TIME OF DEATH 10:30 AM		PLACE OF DEATH HOME		CAUSE OF DEATH HEART DISEASE	
MEDICAL HISTORY HYPERTENSION		PRESENT ILLNESS HEART DISEASE		MEDICAL ATTENDANCE DR. J. E. KELLO		MEDICAL CERTIFICATE OF DEATH YES	
SIGNATURE OF DECEASED JAMES E. KELLO		SIGNATURE OF WITNESS JAMES E. KELLO		SIGNATURE OF PHYSICIAN DR. J. E. KELLO		SIGNATURE OF REGISTRAR JAMES E. KELLO	

BUREAU V. 2

FEB 4 1957

RECEIVED

VS A15 (4)
ISM 9/SS

01597

381

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland 3401-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 3627 Greenmount Avenue	
3. NAME OF DECEASED (Type or print) First Wilhelmina		Last Vogt	
4. DATE OF DEATH Month January 30,		Day 19	
5. SEX female		6. COLOR OR RACE white	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 23, 1884	
9. AGE (In years last birthday) yrs. 72		IF UNDER 1 YEAR Months 12	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY housework	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 660x (b) 660x (c) 660x		INTERVAL BETWEEN ONSET AND DEATH 1 hr 1/2 unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 28, 1948 to Jan 30, 1957 , that I last saw the deceased alive on Jan. 30, 1957 , and that death occurred at 1:35 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Spring Grove ST. Hosiery Co. 3627 Greenmount Ave. Baltimore, Md.	
ACTUAL SIGNATURE Gertrude J. Fleischman		DATE SIGNED Feb 6, 1957	
PHYSICIAN'S NAME (Type) Gertrude J. FLEISCHMAN M.D.		Catonsville 28, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Reburied		22b. DATE THEREOF Feb. 6, 1957	
22c. NAME OF CEMETERY OR CREMATORY Quincy Road U. of Md.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Alfred J. ...		24a. REC'D BY REGISTRAR Alfred J. ...	
24b. REGISTRAR'S SIGNATURE Alfred J. ...		DATE FEB 8 '57	

RECEIVED

382

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Old Court Rd. #131</u>				d. STREET ADDRESS <u>Old Court Rd. #131</u>			
3. NAME OF DECEASED (Type or print) <u>H. W. Paul Voigt</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>30</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 20, 1879</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Otto Voigt</u>				14. MOTHER'S MAIDEN NAME <u>Sophie Whrenberg</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mr. Geo. Voigt - Old Court Rd. #131</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary-Renal Vascular Disease</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov. 13</u> , 19 <u>56</u> , to <u>Jan 30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan. 27</u> , 19 <u>57</u> , and that death occurred at <u>1457</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George E. Shannon</u>				ADDRESS (Street, city or town, state) <u>820 Medical Arts Bldg</u>			
PHYSICIAN'S NAME (Type) _____				DATE SIGNED _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 2, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Stansbury</u>				ADDRESS <u>6411 Windsor M. H.</u>		24a. REC'D BY REGISTRAR <u>Feb 4 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Dr. H. E. Martin</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

BUREAU V. 3

FEB 4 1957

RECEIVED

1
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

00382

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		STATE <u>MARYLAND</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		COUNTY <u>3V01-4</u>	
CITY OR TOWN <u>COCKEYSVILLE</u>		LENGTH OF STAY (in this place) <u>2 YEARS</u>		STREET ADDRESS <u>2438 EDMONDSON AVE</u>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MASONIC HOME</u>							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>LENA</u>		(Middle)		(Last) <u>VOLZ</u>		(Month) (Day) (Year)	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>		8. DATE OF BIRTH <u>9-12-1882</u>	
9. AGE last birthday <u>74</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S</u>		13. FATHER'S NAME <u>CONRAD FUNK</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE E SCHNEIDMILLER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-03-1775 D</u>		17. INFORMANT & ADDRESS <u>Frank L. Smith Jr. Cockeysville, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A) <u>Arterio-Sclerotic Cardio-vascular Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-3</u> , 19 <u>55</u> , to <u>12-31</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12-31</u> , 19 <u>56</u> , and that death occurred at <u>9:15 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Walter T. Lees</u>				ADDRESS (Street, city, town, state) <u>Cockeysville Md.</u>			
DATE SIGNED <u>1/1/57</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>1/5/57</u>		NAME OF CEMETERY OR CREMATORY <u>PARKWOOD CEMETERY</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE MARYLAND.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Alfred Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HENRY SANDER & SONS INC.</u>		ADDRESS <u>BALTIMORE MARYLAND.</u>	
DATE <u>JAN 3 '57</u>							

[illegible]

CERTIFICATE OF DEATH

Reg. Dist. No. 32

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The before copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH COUNTY <u>Balto</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u> TOWN <u>Pikesville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Balto</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u> TOWN <u>Pikesville</u> STREET ADDRESS <u>1</u> (If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>Lillian M. Wagner</u> (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>January 2</u> 19 <u>57</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>5/22/1903</u>
9. AGE last birthday <u>53</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Balto</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John R. Brown</u>		14. MOTHER'S MAIDEN NAME <u>Ida Turnbull</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-18-3234</u>	
17. INFORMANT & ADDRESS <u>Robert J. Wagner, 27 Mac Rd</u>		18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 171X IMMEDIATE CAUSE (A) <u>Uremia</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Urinary Carcinoma & Metastasis</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Metastasis</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma Urinx with Metastasis</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not while at work <input type="checkbox"/> While at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Nov</u> , 19 <u>55</u> , to <u>JAN</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>JAN 2</u> , 19 <u>57</u> , and that death occurred at <u>7:25</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Thomas C. White</u>		DATE SIGNED <u>1/4/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>Dorothy Penells</u>	
DATE <u>1/8/57</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Loring Byers</u> ADDRESS <u>5005 Pk 7th</u>	

00383

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

CERTIFICATE OF DEATH

DATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. OCCUPATION

5. PLACE OF BIRTH

6. DATE OF BIRTH

7. PLACE OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF CORONER

13. SIGNATURE OF JURY

14. SIGNATURE OF JUDGE

15. SIGNATURE OF CLERK

16. SIGNATURE OF REGISTRAR

17. SIGNATURE OF VENDOR

18. SIGNATURE OF BURIAL

19. SIGNATURE OF INTERMENT

20. SIGNATURE OF RECORDS

21. SIGNATURE OF OFFICE

22. SIGNATURE OF DEPARTMENT

23. SIGNATURE OF STATE

24. SIGNATURE OF NATION

25. SIGNATURE OF WORLD

26. SIGNATURE OF UNIVERSE

27. SIGNATURE OF GOD

28. SIGNATURE OF HEAVEN

29. SIGNATURE OF EARTH

30. SIGNATURE OF WATER

31. SIGNATURE OF FIRE

32. SIGNATURE OF AIR

33. SIGNATURE OF LIGHT

34. SIGNATURE OF DARKNESS

35. SIGNATURE OF LIFE

36. SIGNATURE OF DEATH

37. SIGNATURE OF REBIRTH

38. SIGNATURE OF RESURRECTION

39. SIGNATURE OF JUDGMENT

40. SIGNATURE OF GLORY

41. SIGNATURE OF HONOR

42. SIGNATURE OF POWER

43. SIGNATURE OF WEALTH

44. SIGNATURE OF KNOWLEDGE

45. SIGNATURE OF WISDOM

46. SIGNATURE OF FAITH

47. SIGNATURE OF HOPE

48. SIGNATURE OF CHARITY

49. SIGNATURE OF LOVE

50. SIGNATURE OF PEACE

51. SIGNATURE OF JOY

52. SIGNATURE OF SORROW

53. SIGNATURE OF GRIEF

54. SIGNATURE OF PAIN

55. SIGNATURE OF SUFFERING

56. SIGNATURE OF TRIAL

57. SIGNATURE OF TEST

58. SIGNATURE OF PROOF

59. SIGNATURE OF EVIDENCE

60. SIGNATURE OF FACT

BUREAU V. 1

14N 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

00384

2411 N. Charles Street, Baltimore

385 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>A.A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Pasadena 02X02</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House in Pines</u>		STREET ADDRESS (If rural, give location) <u>R.D. 7 Box 167</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>Harry</u> (Middle) <u>R.</u> (Last) <u>Walker</u>		(Month) (Day) (Year) <u>Jan. 25 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct. 7 1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>82</u> yrs.
13. FATHER'S NAME <u>Joseph B. Walker</u>		12. CITIZEN OF WHAT COUNTRY? <u>Pennsylvania</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		17. INFORMANT AND ADDRESS <u>Mrs. Eliz. W. Bushnell 51 W. 71 N.Y.C.</u>	
16. SOCIAL SECURITY No. <u>None</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jane</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Pneumonia, bilateral basilar</u>		Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Hypertension heart disease with old cerebral vascular accident.</u>	<u>1-2 years</u>
Antecedent cause(s) (c) <u>Fracture of back</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 12/31, 1955, to 1/25, 1957, that I last saw the deceased alive on 1/25, 1957, and that death occurred at 11:55 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>1/27/57</u>	<u>Hillcrest</u>	<u>Clearfield Penna.</u>	
DATE REC'D BY LOCAL REG. <u>JAN 29 '57</u>		REGISTRAR'S SIGNATURE <u>Wm J. Tschner & Sons W. Pa.</u>		

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 30 1957
BUREAU Y. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

386

CERTIFICATE OF DEATH

00385
38

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON 55</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>417 JEFFERSON AVE.</u>				d. STREET ADDRESS <u>417 JEFFERSON AVE.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>LELIA F. WALKER</u>				4. DATE OF DEATH Month Day Year <u>29 1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 30, 1900</u>	9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PRIVATE FAMILY</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. BROWN</u>				14. MOTHER'S MAIDEN NAME <u>SOPHIA DERICKS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212 327722</u>		17. INFORMANT <u>Wm. WALKER 417 JEFFERSON AVE.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA, METASTATIC, GENERALIZED</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMA OF BREAST</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>ONE YEAR</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>NOV 29, 1956</u> , to <u>JAN 29, 1957</u> , that I last saw the deceased alive on <u>JAN 29, 1957</u> , and that death occurred at <u>8:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thaddeus P. Siwinski</u>				ADDRESS (Street, city or town, state) <u>17 W. PENNA. AVE., TOWSON, MD.</u>			
PHYSICIAN'S NAME (Type) <u>T. C. SIWINSKI</u>				DATE SIGNED <u>1/30/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIED</u>		22b. DATE THEREOF <u>2/2/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PLEASANT REST</u>		22d. LOCATION (City, town, or county) (State) <u>TOWSON, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. L. Blumstein</u>				ADDRESS <u>1701 McCulloch St.</u>		24a. REC'D BY REGISTRAR <u>Thaddeus P. Siwinski</u>	
				DATE <u>31 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Thaddeus P. Siwinski</u>	

BUREAU V. S.

JAN 31 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00386

387

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		STATE <u>MARYLAND</u>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>COCKEYSVILLE</u>		LENGTH OF STAY (in this place) <u>6 YEARS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MASONIC HOME</u>		STREET ADDRESS (If rural give location) <u>3 VOL-4</u>		STREET ADDRESS (If rural give location) <u>2906 BRIGHTON ST.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>IRVINE</u> (Middle) <u>SPURRIER</u> (Last) <u>WALLACE</u>				(Month) <u>JAN</u> (Day) <u>22</u> (Year) <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>7/21/1884</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STENOGRAPHER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JOSEPH SPURRIER</u>				14. MOTHER'S MAIDEN NAME <u>MARY C. ETCHISON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>Frank L. Smith Jr. Cockeysville Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
422.1 IMMEDIATE CAUSE (A) <u>Arterio-Sclerotic Cardio</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO <u>Vascular disease</u>						<u>1 month</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/3</u> , 19 <u>51</u> , to <u>1/21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/21/57</u> , 19 <u>57</u> , and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Walter T. Hays</u>		M.D. <u>Cockeysville Md.</u>		DATE SIGNED <u>1/22/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>1-24-57</u>		NAME OF CEMETERY OR CREMATORY <u>Pine Grove Mt Airy Md</u>		LOCATION (City, town, or county) (State) <u>Wt Airy Md</u>	
24. REC'D BY REGISTRAR <u>JAN 24 1957</u>		REGISTRAR'S SIGNATURE <u>Frank Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm C. Cook</u>		ADDRESS <u>1517 St Paul St</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

003874

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 34014 ✓				d. STREET ADDRESS <u>1551 N. Gilmore</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES HENRY WATKINS</u>				4. DATE OF DEATH Month Day Year <u>1 8 1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 13, 1903</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Macklenburg, Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Plummer Watkins</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Elvora Watkins 1551 N. Gilmore St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Jack Collins</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JACK C Collins</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Jan 12, 1957</u>		<u>Mt. Auburn Cemetery</u>		<u>Baltimore</u> <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Joseph L. Kues 2222 N. North An. Balto. Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 1/10/57</u>		24b. REGISTRAR'S SIGNATURE <u>Lawson L. Farley</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH		6. TIME OF DEATH	
7. PLACE OF DEATH		8. OCCUPATION		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF EXAMINER		12. SIGNATURE OF WITNESS	
13. HISTORY OF PRESENT ILLNESS		14. PHYSICAL EXAMINATION		15. LABORATORY EXAMINATIONS		16. POST-MORTEM FINDINGS		17. OTHER FINDINGS		18. COMMENTS	
19. MEDICAL HISTORY		20. SOCIAL HISTORY		21. FAMILY HISTORY		22. PREVIOUS ILLNESSES		23. ALLERGIC REACTIONS		24. MEDICATIONS	
25. VITAL SIGNS		26. VITAL SIGNS		27. VITAL SIGNS		28. VITAL SIGNS		29. VITAL SIGNS		30. VITAL SIGNS	
31. VITAL SIGNS		32. VITAL SIGNS		33. VITAL SIGNS		34. VITAL SIGNS		35. VITAL SIGNS		36. VITAL SIGNS	
37. VITAL SIGNS		38. VITAL SIGNS		39. VITAL SIGNS		40. VITAL SIGNS		41. VITAL SIGNS		42. VITAL SIGNS	
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49. VITAL SIGNS		50. VITAL SIGNS		51. VITAL SIGNS		52. VITAL SIGNS		53. VITAL SIGNS		54. VITAL SIGNS	
55. VITAL SIGNS		56. VITAL SIGNS		57. VITAL SIGNS		58. VITAL SIGNS		59. VITAL SIGNS		60. VITAL SIGNS	
61. VITAL SIGNS		62. VITAL SIGNS		63. VITAL SIGNS		64. VITAL SIGNS		65. VITAL SIGNS		66. VITAL SIGNS	
67. VITAL SIGNS		68. VITAL SIGNS		69. VITAL SIGNS		70. VITAL SIGNS		71. VITAL SIGNS		72. VITAL SIGNS	
73. VITAL SIGNS		74. VITAL SIGNS		75. VITAL SIGNS		76. VITAL SIGNS		77. VITAL SIGNS		78. VITAL SIGNS	
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97. VITAL SIGNS		98. VITAL SIGNS		99. VITAL SIGNS		100. VITAL SIGNS		101. VITAL SIGNS		102. VITAL SIGNS	
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187. VITAL SIGNS		188. VITAL SIGNS		189. VITAL SIGNS		190. VITAL SIGNS		191. VITAL SIGNS		192. VITAL SIGNS	
193. VITAL SIGNS		194. VITAL SIGNS		195. VITAL SIGNS		196. VITAL SIGNS		197. VITAL SIGNS		198. VITAL SIGNS	
199. VITAL SIGNS		200. VITAL SIGNS		201. VITAL SIGNS		202. VITAL SIGNS		203. VITAL SIGNS		204. VITAL SIGNS	
205. VITAL SIGNS		206. VITAL SIGNS		207. VITAL SIGNS		208. VITAL SIGNS		209. VITAL SIGNS		210. VITAL SIGNS	
211. VITAL SIGNS		212. VITAL SIGNS		213. VITAL SIGNS		214. VITAL SIGNS		215. VITAL SIGNS		216. VITAL SIGNS	
217. VITAL SIGNS		218. VITAL SIGNS		219. VITAL SIGNS		220. VITAL SIGNS		221. VITAL SIGNS		222. VITAL SIGNS	
223. VITAL SIGNS		224. VITAL SIGNS		225. VITAL SIGNS		226. VITAL SIGNS		227. VITAL SIGNS		228. VITAL SIGNS	
229. VITAL SIGNS		230. VITAL SIGNS		231. VITAL SIGNS		232. VITAL SIGNS		233. VITAL SIGNS		234. VITAL SIGNS	
235. VITAL SIGNS		236. VITAL SIGNS		237. VITAL SIGNS		238. VITAL SIGNS		239. VITAL SIGNS		240. VITAL SIGNS	
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247. VITAL SIGNS		248. VITAL SIGNS		249. VITAL SIGNS		250. VITAL SIGNS		251. VITAL SIGNS		252. VITAL SIGNS	
253. VITAL SIGNS		254. VITAL SIGNS		255. VITAL SIGNS		256. VITAL SIGNS		257. VITAL SIGNS		258. VITAL SIGNS	
259. VITAL SIGNS		260. VITAL SIGNS		261. VITAL SIGNS		262. VITAL SIGNS		263. VITAL SIGNS		264. VITAL SIGNS	
265. VITAL SIGNS		266. VITAL SIGNS		267. VITAL SIGNS		268. VITAL SIGNS		269. VITAL SIGNS		270. VITAL SIGNS	
271. VITAL SIGNS		272. VITAL SIGNS		273. VITAL SIGNS		274. VITAL SIGNS		275. VITAL SIGNS		276. VITAL SIGNS	
277. VITAL SIGNS		278. VITAL SIGNS		279. VITAL SIGNS		280. VITAL SIGNS		281. VITAL SIGNS		282. VITAL SIGNS	
283. VITAL SIGNS		284. VITAL SIGNS		285. VITAL SIGNS		286. VITAL SIGNS		287. VITAL SIGNS		288. VITAL SIGNS	
289. VITAL SIGNS		290. VITAL SIGNS		291. VITAL SIGNS		292. VITAL SIGNS		293. VITAL SIGNS		294. VITAL SIGNS	
295. VITAL SIGNS		296. VITAL SIGNS		297. VITAL SIGNS		298. VITAL SIGNS		299. VITAL SIGNS		300. VITAL SIGNS	

BUREAU V. S.

JAN 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00388

CERTIFICATE OF DEATH

Reg. Dist. No 33

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Md.</u>		c. LENGTH OF STAY IN 1b <u>52 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Ray</u> Last <u>WATSON</u>		4. DATE OF DEATH Month <u>1</u> Day <u>4</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/13/91</u>
9. AGE (In years last birthday) yrs. <u>65</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wharton B. Watson</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Douglas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. ---	
17. INFORMANT <u>Rosewood Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary sclerosis with recent obstruction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Old myocardial infarcts</u> DUE TO (c) <u>Generalized arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity, Imbecillity</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/5/56</u> , 19 <u>56</u> , to <u>2/4/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/4/57</u> , 19 <u>57</u> , and that death occurred at <u>2:15 P.</u> from the causes and on the date stated above. <u>Eugenio Barranco, M.D.</u> ADDRESS (Street, city or town, state) <u>Owings Mills, Md.</u> DATE SIGNED <u>1/4/57</u>			
ACTUAL SIGNATURE <u>Richard Lindenberg, Pathologist</u>		PHYSICIAN'S NAME (Type) <u>Richard Lindenberg, Pathologist</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 8/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rosewood</u>		22d. LOCATION (City, town, or county) (State) <u>Owings Mills Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Elmer-Sons Rustertown Md</u>		24a. REC'D BY REGISTRAR DATE <u>1-7-58</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary B. Elmer</u>			

BUREAU V. E.

JAN 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

390

CERTIFICATE OF DEATH

00389

Reg. Dist. No.

43

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. LENGTH OF STAY IN 1b X0	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		d. STREET ADDRESS 4 Mc Cormick Ave	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Caroline Carrie E Weinberger First Middle Last		4. DATE OF DEATH Jan 24/57 Month Day Year	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 13 1868
9. AGE (In years last birthday) 88		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Geo Spangenberg		14. MOTHER'S MAIDEN NAME Don't know	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Mildred Doyle 4 McCormick Ave		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial failure 422.1 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic cardiac vascular disease DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 1950 , to Jan 24, 1956 , that I last saw the deceased alive on Jan 23, 1956 , and that death occurred at 6 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE D. J. Battaglia MD		ADDRESS (Street, city or town, state) 5829 Belair Rd. Balt. 6, Md.	
DATE SIGNED Jan 29 1957		DATE SIGNED Jan 29 1957	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF January 28 /57	
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn		22d. LOCATION (City, town, or county) (State) Baltimore Co	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Mrs. D. L. Humphrey	

BUREAU V. S.

JAN 29 1957

RECEIVED

391 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Catonsville		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 52 Catonsville			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 Paradise Nursing Home Paradise & Altamont Aves.				STREET ADDRESS 1 104 Symington Avenue (If rural give location)			
3. NAME OF DECEASED: (Type or Print) ETHEL E. WERNIG		(First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH: Jan. 12 19 57			
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married	8. DATE OF BIRTH: Dec. 26, 1876	9. AGE last birthday yrs. 80	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life. even if retired) 2 Housewife		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): England		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Henry Edwards				14. MOTHER'S MAIDEN NAME: Ella Keats			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: N. Y. Joseph Netter 130 E. 67th St. New York			

15. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
332X IMMEDIATE CAUSE (A) Terminal Hypostatic Pneumonia		2 days
ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		10/9/54 ad 12/26/56
443X (B) Cerebral Thrombosis		
(C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Cardio Vascular Disease & Hypertension 20 yrs	
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19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
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21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. at work at work	21F. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 3/22, 1936 , to 1/13, 1957 that I last saw the deceased alive on 1/12, 1957 and that death occurred at 2:00 AM , from the causes and on the date stated above.		
SIGNATURE E. W. Johnson	ADDRESS M. D. 3432 Frederick Ave.	DATE SIGNED 4/14/57

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF Jan. 15, 1957	NAME OF CEMETERY OR CREMATORY Louder Park Cem.	LOCATION (City, town, or county) (State) Baltimore, Md.
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DATE REC'D BY LOCAL REGISTRAR 1/15/57	REGISTRAR'S SIGNATURE R. W. Hedrick	24. FUNERAL DIRECTOR William Cook, Inc.	ADDRESS 1217 St. Paul Street
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MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 17 1957

RECEIVED

87

12

80

Dec. 22, 1950

8.

ATLANTA

Female

White

Married

Housewife

Black and

Henry Edwards

Elia Kears

Joseph Carter 150 E. 57th St. New York

Jan. 16, 1957

Female

William Cook, Inc. 1915 N. 1st St. New York

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sparrows Point Hospital		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MD. b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 1715 E. Lombard St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Stanley Middle Lee Last Wheeler		4. DATE OF DEATH Month 1 Day 23 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 10 1916
9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months 4 Days 10	IF UNDER 24 HRS. Hours 10 Min. 10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pumpman		10b. KIND OF BUSINESS OR INDUSTRY Beth Steel Co	11. BIRTHPLACE (State or foreign country) Spotsylvania Va
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Bossy Wheeler	
14. MOTHER'S MAIDEN NAME Sally Sullivan		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Address Manley E Wheeler 1715 E Lombard Street	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) 420.1 DUE TO stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			INTERVAL BETWEEN ONSET AND DEATH 1 hr.
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE M.B. Davis		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) M.B. Davis, M.D.		DATE SIGNED 1/23/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan 26 1957	22c. NAME OF CEMETERY OR CREMATORY Payles Cemetery	22d. LOCATION (City, town, or county) (State) Payles Orange county Va.
23. FUNERAL DIRECTOR'S SIGNATURE The Dippel brothers		ADDRESS 1800 e Lombard Street	
24a. REC'D BY REGISTRAR Jan 24 1957		24b. REGISTRAR'S SIGNATURE Lawson L. Forkey	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 9,12 Film 9210 2-14-57 et

CERTIFICATE OF DEATH

01604

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY P.G. ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 4yr 8mo 8 dys.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Burns Last White				4. DATE OF DEATH Month 1 Day 30 Year 1957			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-19-86	
9. AGE (In years last birthday) 70 7/8 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized and severe DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 30, 1957 , to Jan. 30, 1957 , that I last saw the deceased alive on Jan. 30, 1957 , and that death occurred at 11:45p M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachslor				M.D. SPRING GROVE STATE HOSPITAL 1-31-57			
PHYSICIAN'S NAME (Type) Stella Wachslor, M. D.				ADDRESS (Street, city or town, state) Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Unburied		22b. DATE THEREOF FEB. 6, 57		22c. NAME OF CEMETERY OR CREMATORY Gr. of Mt. Hed. Inland		22d. LOCATION (City, town, or county) (State) Baltimore, Md	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE Rebecca	

FEB 8 57

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. RACE</p>	
<p>5. DATE OF DEATH</p>		<p>6. PLACE OF DEATH</p>	
<p>7. TIME OF DEATH</p>		<p>8. CAUSE OF DEATH</p>	
<p>9. MANNER OF DEATH</p>		<p>10. SIGNATURE OF PHYSICIAN</p>	
<p>11. SIGNATURE OF REGISTRAR</p>		<p>12. SIGNATURE OF WITNESSES</p>	
<p>13. SIGNATURE OF DECEASED</p>		<p>14. SIGNATURE OF NEXT OF KIN</p>	
<p>15. SIGNATURE OF BURIAL OFFICIAL</p>		<p>16. SIGNATURE OF CHURCH OFFICIAL</p>	
<p>17. SIGNATURE OF MINISTER</p>		<p>18. SIGNATURE OF CHURCH</p>	
<p>19. SIGNATURE OF BURIAL</p>		<p>20. SIGNATURE OF CHURCH</p>	
<p>21. SIGNATURE OF BURIAL</p>		<p>22. SIGNATURE OF CHURCH</p>	
<p>23. SIGNATURE OF BURIAL</p>		<p>24. SIGNATURE OF CHURCH</p>	
<p>25. SIGNATURE OF BURIAL</p>		<p>26. SIGNATURE OF CHURCH</p>	
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<p>65. SIGNATURE OF BURIAL</p>		<p>66. SIGNATURE OF CHURCH</p>	
<p>67. SIGNATURE OF BURIAL</p>		<p>68. SIGNATURE OF CHURCH</p>	
<p>69. SIGNATURE OF BURIAL</p>		<p>70. SIGNATURE OF CHURCH</p>	
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<p>93. SIGNATURE OF BURIAL</p>		<p>94. SIGNATURE OF CHURCH</p>	
<p>95. SIGNATURE OF BURIAL</p>		<p>96. SIGNATURE OF CHURCH</p>	
<p>97. SIGNATURE OF BURIAL</p>		<p>98. SIGNATURE OF CHURCH</p>	
<p>99. SIGNATURE OF BURIAL</p>		<p>100. SIGNATURE OF CHURCH</p>	

BUREAU V. S.

FEB 11 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00392

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. city	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Foreston		c. LENGTH OF STAY IN 1b 1 wk.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Forest Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Samuel Middle Harrison Last Wilhelm		4. DATE OF DEATH Month Jan. Day 16 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 15, 1885
9. AGE (In years and birth day) 71 yrs.		IF UNDER 1 YEAR Months 7 Days 1	
IF UNDER 24 HRS. Hours 1 Min. 15			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Electric Conductor		10b. KIND OF BUSINESS OR INDUSTRY Car	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Wilhelm		14. MOTHER'S MAIDEN NAME Edith Wilhelm	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-10-1120	
17. INFORMANT Stanley Wilhelm		Address Severna Park Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive C-V Disease DUE TO (c) Angina Pectoris		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour none o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE D. D. Caples		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) D. D. Caples, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or other disposition (Specify) Burial		22b. DATE THEREOF Jan. 20, 1957	
22c. NAME OF CEMETERY OR CREMATORY Forest Cemetery		22d. LOCATION (City, town, or county) (State) Balto. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edwin C. Tipton, Hampstead, Md.		ADDRESS Hampstead, Md.	
24a. REC'D BY REGISTRAR DATE 1-17-57		24b. REGISTRAR'S SIGNATURE Mary B. Ehlert	

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

00393

33

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>	
TOWN <u>Owings Mills</u>		LENGTH OF STAY (in this place) <u>5 years</u>		STREET ADDRESS <u>Morrisway Road</u>		STREET ADDRESS (If rural give location) <u>Morrisway Road</u>	
3. NAME OF DECEASED (First) <u>Edith</u> (Middle) <u>Lord</u> (Last) <u>Wills</u>				4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>25</u> (Year) <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>April 1 1892</u>	9. AGE last birthday <u>64</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>John Yox</u>				14. MOTHER'S MAIDEN NAME <u>Ida Mitchell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>SS 215-18-2233</u>		17. INFORMANT & ADDRESS <u>S/Sgt. John A Dever USAF</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
592X IMMEDIATE CAUSE (A) <u>Decompensated Hypertensive C-V Disease</u>						<u>5 yrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Nephritis</u>						<u>15 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Obesity</u>						<u>30 yrs.</u>	
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION <u>none</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>none</u>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>none</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>none</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>none</u>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> <u>none</u>		21f. HOW DID INJURY OCCUR? <u>none</u>			
22. I hereby certify that I attended the deceased from <u>July 3, 1938</u> , to <u>Jan. 25, 1957</u> , that I last saw the deceased alive on <u>Jan. 24, 1957</u> , and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>D. A. Copley</u>				ADDRESS (Street, city, town, state) <u>M.D. 6 Hanover Rd., Reisterstown, Md.</u> DATE SIGNED <u>1/26/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan 28 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Deer Park Cemetery</u>		LOCATION (City, town, or county) (State) <u>Reisterstown Md</u>	
24. REC'D BY REGISTRAR <u>Jan 29 1957</u>		REGISTRAR'S SIGNATURE <u>Mary Elise</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>um. Bevyman + Sons Reisterstown, Md</u>		ADDRESS	

00394

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

396 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>17409 Western Ave</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>OR</u> TOWN <u>Loch Raven Blvd</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>17409 Western Ave</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>OR</u> TOWN <u>Loch Raven Blvd</u> STREET ADDRESS (If rural, give location) <u>17409 Western Ave</u>	
3. NAME OF DECEASED (Type or Print) <u>Wayne S Wilt</u> (First) (Middle) (Last)		4. DATE OF DEATH <u>Jan 29</u> (Month) (Day) (Year) <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Infant</u>	8. DATE OF BIRTH <u>May 5</u> 19 <u>56</u>
9. AGE last birthday <u>8</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Elmer B. Wilt</u>		14. MOTHER'S MAIDEN NAME <u>Ruby Laird</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4928 Immediate cause (a) Virus pneumonia

Antecedent cause(s) (b)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 1/27, 1957, to 1/29, 1957, that I last saw the deceased alive on 1/28, 1957, and that death occurred at 2 57 m., from the causes and on the date stated above.

SIGNATURE Wm. L. ...

(Degree or title)

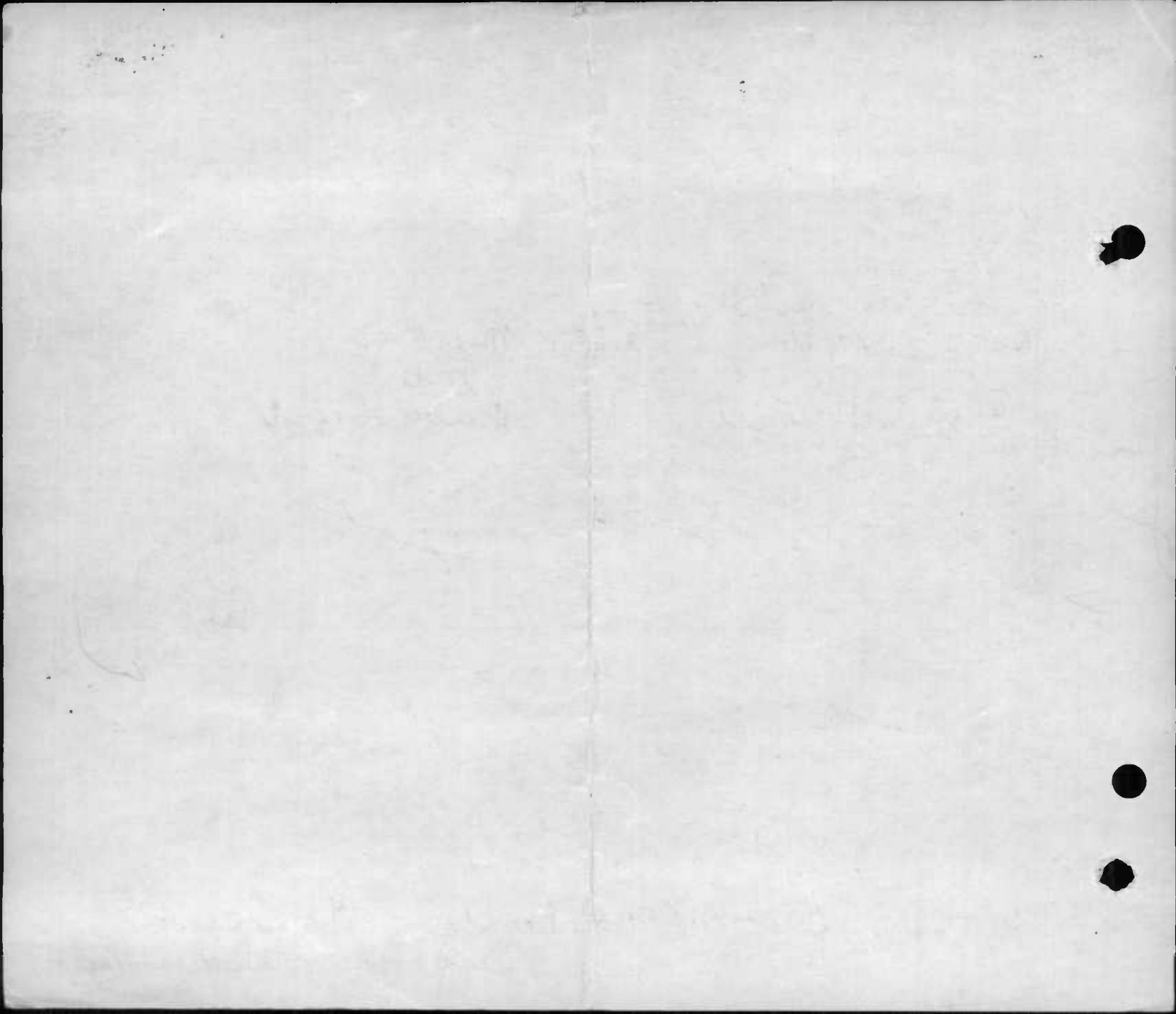
ADDRESS 8402 Greenway RdDATE SIGNED 1/30/57

23. BURIAL OR CREMATION (Specify)	DATE THEREOF <u>Feb 12 1957</u>	NAME OF CEMETERY OR CREMATORY <u>Morelands</u>	LOCATION (City, town, or county) <u>Taylor Ave</u>	(State) <u>MD</u>
DATE REC'D BY LOCAL REG. <u>1-31-57</u>	REGISTRAR'S SIGNATURE <u>Wm. L. ...</u>	24. FUNERAL DIRECTOR <u>Geo. S. Book</u>	ADDRESS <u>1701-03 Patterson Park Ave</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00395

Reg. Dist. No. 75

It is Film G210 2-13-57 et

397

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALT.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essey</u>		c. LENGTH OF STAY in 1b <u>1 yr.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 268 Hollymeck Rd.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essey (21) 54</u>	
f. STREET ADDRESS <u>Box 268 Hollymeck Rd.</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Anthony J. Winkes</u>		4. DATE OF DEATH Month Day Year <u>JAN 24 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>9-2-7-97</u>
9. AGE (in years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None WELDER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED.</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTO. MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>ANTHONY J. WINKES</u>		14. MOTHER'S MAIDEN NAME <u>MARYA COAKLEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>YES WWI</u>		16. SOCIAL SECURITY NO. <u>215-24-2908</u>	
17. INFORMANT <u>Stella Winkes</u>		Address <u>5222 Harford Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Arteriosclerotic Heart Disease</u> DUE TO (b) <u>Syn</u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Alcoholism</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Jack Collins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JACK C. COLLINS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/29/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James J. Brundage</u>		ADDRESS <u>1401 Eastern Ave</u>	
24a. REC'D BY REGISTRAR <u>1/24/57</u>		24b. REGISTRAR'S SIGNATURE <u>Smith Hurley</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

30519

9. *Journal of the American Medical Association*, 277: 1033-1034, 1997.

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FEB 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

398

CERTIFICATE OF DEATH

Reg. Dist. No. 38

00396

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ohio b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TIMONIUM				c. LENGTH OF STAY IN 1b 72x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 47 TIMONIUM ROAD				d. STREET ADDRESS 489 Northview Drive			
3. NAME OF DECEASED (Type or print) ROSE First REBECCA Middle WOLFE Last				4. DATE OF DEATH JAN 2 Month 1957 Day Year			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 15, 1872	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John Geiss				14. MOTHER'S MAIDEN NAME Julia Bier			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Family Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRO-VASCULAR ACCIDENT 831X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 3 MOS.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 20, 1956 to JAN 2, 1957 , that I last saw the deceased alive on JAN 2, 1957 , and that death occurred at 6:15 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE William A. Pillsbury				ADDRESS (Street, city or town, state) Timonium, Maryland		DATE SIGNED Jan. 3, 1957	
PHYSICIAN'S NAME (Type) William A. Pillsbury M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 7, 1957		22c. NAME OF CEMETERY OR CREMATORY Forest Rose Cemetery		22d. LOCATION (City, town, or county) (State) Lancaster, Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE John Burne Stone				ADDRESS Towson, Maryland		24a. REC'D BY REGISTRAR Jan. 3, 1957	
				24b. REGISTRAR'S SIGNATURE Mabel C. Gray			

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]	
DATE OF BIRTH [Faint text, possibly "Jan 1, 1900"]		PLACE OF BIRTH [Faint text, possibly "Boston, Mass."]	
OCCUPATION [Faint text, possibly "Clerk"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]	
DATE OF DEATH [Faint text, possibly "Jan 15, 1957"]		PLACE OF DEATH [Faint text, possibly "Home"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]	
CITY [Faint text, possibly "Boston"]		COUNTY [Faint text, possibly "Suffolk"]	
STATE [Faint text, possibly "Massachusetts"]		YEAR [Faint text, possibly "1957"]	

BUREAU V. 1

JAN 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00397

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 3mth6dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 412 Bulter Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Martha Middle E. Last Ziegler				4. DATE OF DEATH Month January Day 11 Year 19 57			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 8, 1869	
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (b) Pulmonary abscesses (a), stating the underlying cause last. DUE TO Pulmonary abscesses (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
Fracture of left femur							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) on 10-23-56 , patient allegedly slipped on floor and fell, sustaining fracture of left hip			
20c. TIME OF INJURY Month, Day, Year 4:00 a.m. 10-23-56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital		20f. (City or town) (County) (State) Catonsville, 28, Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>George M. Kieffer</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) George M. Kieffer, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 1-11-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/14/57		22c. NAME OF CEMETERY OR CREMATORY LOUNSON PK		22d. LOCATION (City, town, or county) (State) FREDERICK AVE	
23. FUNERAL DIRECTOR'S SIGNATURE GEO LEIMBACH				ADDRESS 525 N LYNDA HURST ST			
24a. REC'D BY REGISTRAR JAN 14 57				24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		45		Jan 1, 1912	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
Boston, Mass.		Boston, Mass.		Heart Disease		Natural	
Occupation		Education		Previous Illnesses		Drugs Taken	
Teacher		High School		Hypertension		None	
Date of Death		Time of Death		Place of Death		Physician	
Jan 14, 1957		10:30 AM		Home		Dr. Smith	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED
JAN 14 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

400

CERTIFICATE OF DEATH

00398

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point (Edgemere)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7403 North Point Road		d. STREET ADDRESS 7403 North Point Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary M. Zaloski (Zolosky)		4. DATE OF DEATH January 29 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 15, 1880
9. AGE (In years last birthday) 76		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Kordonski		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Clara Doerr		Address 7405 North Point Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 260 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes Mellitus DUE TO (c) Arteriosclerotic Heart Disease			INTERVAL BETWEEN ONSET AND DEATH 1 hr. 3 yrs 2 1/2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.0			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 19 55 to Jan. 29, 19 57 , that I last saw the deceased alive on Jan. 29, 19 57 , and that death occurred at 4:00 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE James T. Means		ADDRESS (Street, city or town, state) 570 S. St. Balt. 19 Md	
PHYSICIAN'S NAME (Type) James T. Means		DATE SIGNED 1/30/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 2, 1957	22c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Mary	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc., 403 S. Wolfe Street		24b. REGISTRAR'S SIGNATURE Samson L. Farkas	
24a. REC'D BY REGISTRAR FEB 1 1957		DATE 1957	

BUREAU A. S.

FEB 4 1957

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